NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

OCTOBER 5, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Blair Contratto, Vice Chair
Debra Baetz	Isabel Becerra
Supervisor Doug Chaffee	Norma García Guillén
José Mayorga, M.D.	Supervisor Vicente Sarmiento
Trieu Tran, M.D.	Vacant

Supervisor Donald Wagner, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	Sharon Dwiers

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 identifying the item 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 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 materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_Uue-rk8JRrCA7JZWNOJbMg and Join the Meeting.

Webinar ID: **851 8022 6041**

Passcode: **776750** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Celebrating Employee Milestone Work Anniversaries

MANAGEMENT REPORTS
2. Chief Executive Officer Report

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
3. Minutes
   a. Approve Minutes of the September 7, 2023 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the May 22, 2023 Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

4. Authorize Actions Related to Emergency Repair for CalOptima Health Facility

5. Authorize Actions Related to Permanent Supportive Housing Pilot Program

6. Approve Actions Related to CalOptima Health Street Medicine Program

7. Adopt Resolution No. 23-1005-01 Approving the Revised 2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan; and the 2024 CalOptima Health HIPAA Privacy and Security Program, and the Revised CalOptima Health Office of Compliance Policies and Procedures.

8. Receive and File:
   a. August 2023 Financial Summary
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS
9. Recommend that the Board of Directors Accept and Receive and File Fiscal Year 2022-23 CalOptima Health Audited Financial Statements

10. Ratify Actions Related to Purchasing the Garden Grove Street Medicine Support Center

11. Approve Policy for Election of Officers

12. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ankura Consulting Group, LLC to Provide Professional Services to Review External Grants and Other Internal Initiatives

13. Approve Actions Related to the CalOptima Health Community Reinvestment Program for Medi-Cal Members for Calendar Year 2024

14. Approve Actions Related to the Housing and Homelessness Incentive Program

15. Approve Actions Related to Street Medicine Program Expansion

16. Approve Amendments to Hospital Services Contract with Kindred Hospitals

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on October 5, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_Uue-rk8JRrCA7JZWNOJbMg

To **Join** from a PC, Mac, iPad, iPhone or Android device:
https://us06web.zoom.us/s/85180226041?pwd=jIOtyI415BhNUd7wzRJr2wp1itApXl.1

Passcode: 776750

Or One tap mobile:
+16694449171,,85180226041#,,,,*776750# US
+17207072699,,85180226041#,,,,*776750# US (Denver)

Or join by phone:
Dial (for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968

Webinar ID: 851 8022 6041
Passcode: 776750

International numbers available: **https://us06web.zoom.us/u/kc1S9OwZN5**

CalOptima Health

Celebrating Employee Milestone Work Anniversaries

November 2022-October 2023

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Back to Agenda

15 Years

- **Sabrina Brannon**, Project Manager, Enterprise Project Mgmt. Office
- **Joanna Lake**, ITS Product Manager, ITS - Applications Management
- **Renato Layug**, Claims Examiner Sr., Claims Administration
- **Abraham Manase**, Data Analyst Sr., Quality Analytics
- **Victor Mendez**, Personal Care Coordinator, Case Management
- **Brenda Nemeth**, Program Specialist, Utilization Management
- **Fabiola Nunez**, Grievance Resolution Specialist, Grievance and Appeals
- **Ryan Prest**, Manager Purchasing, Budget and Vendor Management
- **Astrid Sanchez**, Community Partner, OneCare Sales and Marketing
- **Blanca Trujillo**, Project Specialist, Population Health Management

Back to Agenda

CalOptima Health

20 Years

- **Marie Jeannis**, Executive Director, Population Health Management
- **Melanie Laase**, Sr Manager, IS Enterprise Data/Systems Integrations
- **Sally Menchaca**, Community Partner, OneCare Sales and Marketing
- **Julie Newman**, Human Resources Representative Sr., Human Resources
- **Maria Oseguera**, Program Specialist, Cultural and Linguistic Services
- **Olga Trujillo**, Applications Analyst Sr., ITS – Applications Management
- **Terri Wong**, Data and Reporting Analyst – Lead, Quality Analytics

Back to Agenda

CalOptima Health

25 Years

- **Angie Becerra**, Community Partner Sr., OneCare Sales and Marketing
- **Holly Dinh**, Business Analyst Sr., Claims Administration
- **Kris Gericke**, Director, Pharmacy Management
- **Helen Nguyen**, Technical Analyst Sr., ITS – Applications Management
- **Frank Vega**, ITS Administrator Sr., ITS – Infrastructure

Back to Agenda

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Back to Agenda

MEMORANDUM

DATE:	September 29, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — October 5, 2023, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Street Medicine Support Center Garners Media

CalOptima Health distributed a press release announcing plans to acquire, renovate and open a 52-room Street Medicine Support Center in Garden Grove to house individuals who qualify and are referred by our Street Medicine clinical team. The property closed escrow on September 25. Media coverage to date includes:

- On September 14, KFI aired an interview with Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM.
- On September 22, ABC7 ran a package that featured an on-camera interview with Bruno-Nelson.

B. CalOptima Health Is a 4-Star Medi-Cal Plan in California

I am honored to share that, for the ninth year in a row, CalOptima Health is among the top plans in the state. We earned a rating of 4 stars out of 5 stars in the National Committee for Quality Assurance's (NCQA) Medicaid Health Plan Ratings 2023. No other Medi-Cal plan in the state earned higher than 4 stars. This latest NCQA rating measured performance in 2022 and is based on standardized, audited data regarding clinical performance and member satisfaction. NCQA assesses Medicaid plan quality based on 45 clinical measures, including preventive services to keep members healthy and treatments in response to illnesses and chronic diseases. NCQA also evaluates a plan based on customer satisfaction. This sustained record of quality care is truly remarkable, and on behalf of our members, I would like to thank our provider partners for their commitment to serving Orange County's vulnerable residents.

C. Medi-Cal Renewal Efforts Expand

CalOptima Health and the County of Orange Social Services Agency (SSA), along with the entire State of California, are approximately six months into the 14-month process to restart Medi-Cal eligibility renewals. Our multifaceted outreach and awareness efforts have been well received. CalOptima Health intends to maintain established activities and even expand in key areas, such as texting and advertising. Since membership numbers fluctuate during the month and outreach activities are continually adjusted, I will share further updates at the Board meeting on October 5. Please see below for brief summaries of several of our outreach tactics.

- **Customer Service Calls**
  Our Customer Service staff continues to outreach to members who have not returned their renewal packets. We are prioritizing members at higher risk for losing coverage, such as dual-eligible members in OneCare. As a result, 138 OneCare members with a September renewal month were called. Also, 3,927 Medi-Cal members with a September renewal month were engaged through inbound and outbound calls. Further, our new community-based navigators are also adding to our capacity for outreach as they began participating in the call campaigns in September. As more navigators are added in the months ahead, we will be able to reach an even larger number of members needing to renew their coverage.
- **City Presentations**
  In September, SSA Director An Tran and I made presentations about Medi-Cal renewal to city councils in Fullerton and Garden Grove. The material was well received, as the cities plan to help residents understand the need to take action to determine their continued eligibility for Medi-Cal.
- **Texting Campaigns**
  In September, CalOptima Health launched a new type of text campaign to members whose coverage was terminated. Thus far, we have engaged members with a July renewal month (10,852 phone numbers) and August renewal month (10,682 phone numbers) to encourage them to take action to be reinstated during the 90-day window when there will be no gap in coverage. Our other text campaigns continue as well, with outreach to future monthly cohorts to collect address updates, as well as reminders for members to return their packets.
- **Advertising Campaign**
  The Department of Health Care Services (DHCS) has been running a statewide advertising campaign to raise awareness regarding Medi-Cal renewal and options for the California Exchange. CalOptima Health's communications team will soon launch supplemental awareness advertising with a deeper reach within Orange County specifically. The comprehensive campaign will include digital, print, radio and outdoor advertising, from October 2023 through May 2024.

D. Chief Health Equity Officer Joins CalOptima Health

On September 25, CalOptima Health welcomed Michaell Silva Rose, DrPH, LCSW, to the new role of Chief Health Equity Officer. DHCS asked all Medi-Cal managed care plans to appoint a leader to this position by January 1, 2024. Dr. Rose will have input on and oversight of key equity initiatives, benefits, policies and procedures, seeking to better identify and address health inequalities and social determinants of health for CalOptima Health members. She is a bilingual (Spanish) and culturally competent leader with public health and mental health expertise. She has more than 25 years of executive leadership in advocacy, strategic planning, program development, and promotion of equity and improved health outcomes for vulnerable populations. Most recently, Dr. Rose served as Director of Community Health at Hoag Health System where she worked in various leadership roles since 1998. She is currently a member of several boards and community advisory committees, including Be Well OC's Community Suicide Prevention Initiative, Families and Communities Together's leadership council, and Equity in OC's Community Health Improvement Leadership Academy. She has also received several honors and awards, including being named 2023 Woman of the Year by the 46th Congressional District. She earned a bachelor's degree in psychology and a Master of Social Work from California State University, Long Beach, and a Doctorate of Public Health from Loma Linda University School of Public Health.

E. State Legislature Adjourns for 2023

On September 14, the State Legislature adjourned for the remainder of 2023. Next, Gov. Gavin Newsom has until October 14 to sign or veto any legislation passed by the Legislature. Since this is the first year in the two-year 2023–24 legislative session, any unpassed bills may be reconsidered in 2024. In partnership with our state trade associations, CalOptima Health successfully educated legislators and advocated in consideration of proposed legislation's potential impact on members. While more work remains next year, this is a testament to CalOptima Health's growing influence in Sacramento. Staff will continue to monitor actions by the governor over the next several weeks and then provide a final update regarding significant legislation. In the meantime, Gov. Newsom has already signed into law Assembly Bill 271, authored by Assemblymember Sharon Quirk-Silva and formally supported by CalOptima Health, which authorizes counties to create Homeless Death Review Committees that facilitate in-depth data sharing to better identify factors contributing to deaths among unhoused individuals.

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

- **PACE 10th Anniversary and Tours**
  CalOptima Health PACE celebrated its 10th anniversary with a week of activities from September 25–29. Across the decade, PACE has served more than 1,000 older adults in Orange County. Recognition of this major milestone included daily events and entertainment for participants and their families. During the celebration, CalOptima Health and the Association of California Cities – Orange County (ACC-OC) co-hosted a PACE tour/lunch with several mayors and city council members. We will also be hosting a second event with federal and state legislators on October 10.
- **PACE Participant Video**
  CalOptima Health is producing a series of inspirational videos about members as part of our brand awareness campaign. The videos will be used in community presentations and other outreach efforts to increase awareness and understanding of our agency. The most recent video features Lilia Lopez who shares her story about living with diabetes and how being a PACE participant for the past six years has helped her stay healthy. The video can be viewed here.
- **PACE Accolades**
  A PACE participant recently shared some thoughtful words of appreciation for the care she has received: "I am very grateful for PACE and all its amazing caring staff who are always willing to go above and beyond for me and my husband and for others. These past nine months since I have been enrolled, PACE has completely changed my point of view in my life. There have been times in my life when I felt like giving up due to current my medical problems. But coming to PACE makes me forget about all that and focus on the positive. I am very content with the music, activities, rehab, food, and the care that the staff provides for me. You all have given me a reason to smile and live longer. ¡Que viva CalOptima PACE!"

G. CalOptima Health Executives Earn Honors

- **Chief Information Officer Named CIO of the Year**
  On September 14, Chief Information Officer Wael Younan was presented with The Global Leadership Institute Award for CIO of the Year during the HMG Strategy Conference in Huntington Beach. He also spoke on an executive panel at the conference on the topic of cybersecurity and artificial intelligence.
- **Executive Director, Behavioral Health Integration Appointed to Behavioral Health Task Force**
  Dr. Mark Ghaly, Secretary of the California Health & Human Services Agency, has appointed Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, to serve as a member of Gov. Gavin Newsom's Behavioral Health Task Force (BHTF). Carmen's unique

perspective and expertise will play a significant role in California's collective efforts to address systemic challenges, promote equity and drive positive change in behavioral health care. Her selection reflects her qualifications and demonstrated commitment to making a meaningful impact in Orange County and throughout California. Carmen's first quarterly BHTF meeting is on October 11.

H. COVID-19 Vaccine Data Shows the Rate of Vaccinations Among Members

As COVID-19 is increasing this fall, CalOptima Health is continuing to encourage members to get vaccinated. The Member Health Rewards program incentive for receiving a COVID-19 vaccination or booster will run until December 31, 2023. As of September 4, the number of members who have been vaccinated reached 562,794. Of note, the vaccination rate for members age 65+ is 81%. And, in our PACE program, 91% are fully vaccinated.

I. Hospital Association of Southern California Sends Letter to Board

On September 5, the Board received a letter from the Hospital Association of Southern California (HASC) sharing concerns about the status of safety net hospitals and physicians. At CalOptima Health's September 7 Board meeting, a representative from HASC spoke during the public comments and referred to the letter. In the letter, HASC proposes that CalOptima Health establish a permanent Board Ad Hoc Safety Net Subcommittee tasked with developing needed short-term and long-term safety net investments and initiatives, among other requests. Please see the attached letter.

J. CalOptima Health Gains Media Coverage and Public Recognition

With our ongoing innovation and program development, CalOptima Health continues to receive positive and valuable media coverage and public recognition.

- On September 4, the California School Boards Association (CSBA) published a blog about CalOptima Health's Student Behavioral Health Incentive Program (SBHIP) funding in Orange County schools. CSBA is the nonprofit education association representing the elected officials who govern public school districts and county offices of education.
- On September 6, Kelly Bruno-Nelson, Executive Director of Medi-Cal/CalAIM, was a featured speaker at the 2023 Southern California State of Reform Health Policy conference in Pasadena. She discussed how CalOptima Health is working to increase supportive and affordable housing in Orange County through CalAIM. State of Reform published this article after the conference.
- On September 7, U.S. Rep. Katie Porter posted on Threads about CalOptima Health's SBHIP investment: "Across the country, schools are struggling to find mental health professionals to support students. @caloptima's investment in behavioral health for Orange County children is an important example of how we address the youth mental health crisis."
- On September 15, Becker's Payer included CalOptima Health's NCQA rating in a listing of the best-rated Medicaid plans of 2023.

CalOptima Health

Fast Facts
October 2023

Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.

Membership Data* (as of August 31, 2023)

Total CalOptima Health Membership

990,241

Program	Members
Medi-Cal	971,994
OneCare (HMO D-SNP)	17,815
Program of All-Inclusive Care for the Elderly (PACE)	432

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for two months ended August 31, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$725,117,707	$718,596,829	$6,520,878
Medical Expenses	$650,999,667	$669,749,885	$18,750,218
Administrative Expenses	$34,102,163	$41,194,042	$7,091,879
Operating Margin	$40,015,877	$7,652,902	$32,362,975
Medical Loss Ratio (MLR)	89.8%	93.2%	(3.4%)
Administrative Loss Ratio (ALR)	4.7%	5.7%	1.0%

Reserve Summary (as of August 31, 2023)

	Amount (in millions)
Board Designated Reserves	$581.0*
Capital Assets (Net of depreciation)	$84.6
Resources Committed by the Board	$608.3
Resources Unallocated/Unassigned	$443.2
Total Net Assets	$1,717.2

Total of Board designated reserves and unallocated resources can support approximately 93 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

NOTE: CalOptima Health receives its funding from state and federal revenues only. CalOptima Health does not receive any of its funding from the County of Orange.

CalOptima Health Fast Facts

October 2023

Personnel Summary (as of September 9, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,350.8	42.1	3.02%
Supervisor	80	4	4.76%
Manager	115	10	8%
Director	57.0	6.5	10.24%
Executive	21	1	4.55%
Total FTE Count	1,623.8	63.6	3.77%

FTE Count based on position control reconciliation and includes both medical and administrative positions.

Provider Network Data (as of August 31, 2023)

	Number of Providers
Primary Care Providers	1,289
Specialists	8,596
Pharmacies	561
Acute and Rehab Hospitals	43
Community Health Centers	52
Long-Term Care Facilities	104

Treatment Authorizations (as of July 31, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	10.97 hours
Prior Authorization – Urgent	72 hours	16.23 hours
Prior Authorization – Routine	5 days	1.75 days

Average turnaround time for routine and urgent authorization requests for CalOptima Health Community Network.

Member Demographics (as of August 31, 2023)

Member Age	
0 to 5	8%
6 to 18	25%
19 to 44	35%
45 to 64	20%
65 +	12%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

HOSPITAL ASSOCIATION of Southern California

September 5, 2023

Mr. Clayton Corwin
Chair, CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

RE: A Shared Community Blueprint to Preserve Access to the Orange County Safety Net

Dear Chair Corwin:

The Hospital Association of Southern California (HASC), along with other community stakeholders and organizations, was integrally involved in founding, designing and implementing CalOptima Health three decades ago. Fundamentally, this launch involved a shared commitment to creating a better system of care for Orange County's Medi-Cal and other underserved residents through an unprecedented public-private partnership.

We also appreciate and want to acknowledge the interim, temporary COVID-19 rate augmentations your Board provided and subsequently extended. However, the generational COVID-19 pandemic has shaken the county's safety net to its core. Extraordinary increased costs and related issues continue impacting those who shoulder the greater burdens in providing care and services to CalOptima Health members.

Over the years, the original public-private partnership featured consistent, proactive collaboration in formulating short- and long-term strategies to help absorb the subsequent enormous increase in CalOptima Health enrollments. During this period, volunteer hospital and physician leaders stepped up from our organizations and were appointed by the Board of Supervisors to serve on the CalOptima Health Board and in other advisory capacities.

The benefits of a working and positive partnership cannot be understated. Orange County has no county hospital, primary or specialty care clinic, or network of care. Physicians, community clinics and hospitals are the de facto private safety net for all Orange County residents. Within that framework, the burden of caring for Medi-Cal enrollees is not shared equitably, placing an absolute premium on maintaining that foundational relationship and partnership.

Unfortunately, in recent years this critical dynamic has diminished. Very little consistent or proactive strategic planning has taken place, particularly with respect to major initiatives launched by CalOptima Health, including those directly impacting core safety net hospitals and physicians. Few, if any, meaningful collaborative efforts have materialized. Qualified physician and current hospital leaders nominated by our organizations have not been appointed to the CalOptima Health Board, while others who ably served were not reappointed.

At the same time, over the past two years the agency has voted to allocate hundreds of millions of dollars (including from reserves) for an array of new programs that often have not directly related to the provision of medical services or served to stabilize critical core safety net providers and our services.

One major example is the hospital quality improvement program initiative recently adopted by CalOptima Health. This major investment of $153 million over five years is also a major opportunity to benefit the safety net and enrollees — yet it was launched without any concerted input into its development from the very hospitals it is intended to assist. Our repeated efforts to engage with CalOptima Health leadership to work together and recast that program to truly benefit and strengthen the safety net have failed.

The fact that one in three Californians is now enrolled in Medi-Cal has dramatically escalated the ongoing financial impact of the program's chronic underfunding. Requests to CalOptima Health for urgent one-time supplemental payments to safety net hospitals to even modestly offset annual Medi-Cal funding shortfalls (typically exceeding $500 million annually in Orange County) failed to gain traction. For physicians, direct base funding and rate increases — or even modest cost-of- living increases — have not occurred despite the unprecedented surge in Medi-Cal enrollees.

In summary, we believe that we no longer share a common "roadmap" with CalOptima Health. However, we do believe a key recommendation from the recent California State Auditor report on CalOptima Health provides an ideal vehicle to restore and reinvigorate a true public-private partnership between safety net providers and your agency, specifically in creating an annual spending and investment plan that includes short- and long-term deployment of a portion of the massive excess reserves identified in that audit.

As a result, on behalf of our hospital members in Orange County, HASC formally requests the following of the CalOptima Health Board:

- Establish a permanent Board Ad Hoc Safety Net Subcommittee tasked with developing needed short-term and long-term safety net investments and initiatives. This annual "Safety Net Preservation Blueprint" will help ensure the long-term stability of Orange County's health care safety net and the providers who shoulder a disproportionate share of that burden;
- Direct the Ad Hoc Subcommittee to develop such a multiyear spending plan beginning in FY23-24 for incorporation into CalOptima Health's upcoming budget year; and
- Freeze or postpone any new program or policy initiatives that would draw on CalOptima's remaining unencumbered reserves. This action would permit the Ad Hoc Subcommittee to develop its initial and subsequent annual Safety Net Preservation Blueprint plans for consideration and adoption by the full Board.

Attached is our initial working list of such needed investments and initiatives. Please note that list items are not all related to increased rates, but also include programmatic and operational investments to ensure that CalOptima Health enrollees receive the right care at the right time and in the right setting. The preliminary list is compelling by any measure and, in many cases, reflects issues the provider community has raised previously to CalOptima Health.

We acknowledge that even this partial working list may be beyond CalOptima Health's near-term ability to fund or that it will take time to implement certain operational and programmatic changes. That should not, however, be a reason for inaction. Moreover, such direct engagement may yield even more impactful solutions that enhance the quality of care for CalOptima Health enrollees and hopefully incentivize more providers to participate in Medi-Cal, thereby expanding access to care.

Such a permanent direct partnership will also permit CalOptima Health and the broader health care community to remain flexible and to better anticipate, integrate and maximize the impact of future state and federal funding and policy initiatives. These changes include the recently approved managed care organization tax on California's health plans, the bulk of which is not anticipated to flow into the Medi-Cal

program until CY2025.

HASC's leadership and member organizations are fully committed and stand ready to immediately begin this important work with the Ad Hoc Subcommittee and CalOptima Health executive leadership. We strongly believe that only by undertaking this effort can we renew and reinvigorate the historical public-private partnership between our organizations on behalf of the community we serve.

Please join us in this important work and thank you for considering our heartfelt views on these urgent matters.

Most sincerely,

George Greene President and CEO
Hospital Association of Southern California

cc: Michael Hunn, CEO, CalOptima Health
Members, Orange County Board of Supervisors
Orange County Hospital CEOs
William O. Woo, MD, President, Orange County Medical Association
James Peterson, Executive Director, Orange County Medical Association
Sharon Dwiers, Clerk of the Board, CalOptima

Annual Blueprint to Preserve Access to the Orange County Safety Net Recommended Partnership Initiatives and Investments

- Revise and maximize the impact of CalOptima Health's hospital quality improvement initiative.
- Annual cost-of-living and other base increases in physician and hospital funding or, in lieu of base funding increases, direct supplemental pass-through payments to physicians and hospitals based on the individual share of CalOptima enrollees to whom they provide care each year.
- Targeted increases for key physician inpatient and outpatient specialties, including but not limited to anesthesia, emergency medicine and others. These increases would include incentives or additional case rates to ensure adequate specialty coverage in all hospital emergency departments for physicians treating CalOptima Health enrollees.
- Eliminate operational barriers impacting hospital and physician throughput by creating suitable incentives to ensure patients are discharged or transferred in a timely manner to the most appropriate setting, including but not limited to intermediate care, skilled nursing and rehab facilities.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

September 7, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on September 7, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Chair Corwin called the meeting to order at 1:58 p.m., and Director Jose Mayorga, M.D., led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Debra Baetz (non-voting); Isabel Becerra; Supervisor Doug Chaffee; Norma García Guillén; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento (at 2:05 p.m.); Trieu Tran, M.D.

(All Board members in attendance participated in person)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

The Clerk noted for the record that staff is recommending that the Board hear Agenda Item 3 prior to hearing Agenda Item 2.

Chair Corwin announced that the Board will hear Agenda Item 20 after Closed Session.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer (CEO), presented his report and started by providing an update on Medi-Cal redetermination efforts. Mr. Hunn thanked Director Bates, who is also the Interim Director at the Orange County Health Care Agency, and An Tran, Director of the Social Services Agency (SSA), for their collaboration regarding Medi-Cal redetermination. He noted that, starting in January 2024, individuals regardless of age that are undocumented will now be eligible for full scope Medi-Cal benefits. Mr. Hunn also noted that the requirement to disclose ownership in housing drops off in January and is no longer an impediment to anyone who may have been ineligible as a result of real estate holdings.

Mr. Hunn and Yunkyung Kim, Chief Operating Officer, responded to Board member questions regarding redetermination efforts.

Supervisor Chaffee thanked staff at CalOptima Health and county staff for continuing to educate him on

membership qualifications and benefits. Supervisor Chaffee also mentioned that CalOptima Health has a presentation coming up in Fullerton and noted that since that city is in the Fourth District, to please include him in those presentations, and he can reinforce the message. Supervisor Chaffee also noted that Supervisor Sarmiento would appreciate the same when CalOptima Health gives presentations to cities in the Second District.

Mr. Hunn reviewed the Fast Facts data, noting that currently CalOptima Health serves 979,618 individuals. CalOptima Health spends 87.9% of every dollar on medical care, and 4.6% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $579.0 million; its capital assets are $83.9 million; its resources committed by the Board are $650.4 million; and its unallocated and unassigned resources are $397.0 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.7 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are over 1,500 employees with a vacancy/turnover rate of about 5.96% as of the August 12, 2023, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 9,943 providers, 1,292 primary care providers, and 8,651 specialists; 560 pharmacies; 43 acute and rehab hospitals; 52 community health centers; and 104 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that this data is as of June 30, 2023. For urgent inpatient treatment authorizations, the average approval is within 18.68 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 17.24 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.84 days; the state-mandated response is 5 days.

Mr. Hunn updated the Board on several other topics which included: Street Medicine Program success, the media event on August 15 at which Representatives Lou Correa and Young Kim awarded $2 million to support the CalOptima Health Traffic Control Command Center that will be located on the third floor of the 500 Building, and the first report on CalAIM services. Mr. Hunn also updated the Board and members of the public on another funding opportunity related to the Nonprofit Healthcare Academy, which is part of the Housing and Homelessness Incentive Program.

Mr. Hunn announced that CalOptima Health is excited to welcome three new medical directors who recently joined CalOptima Health: Natalie Do, Pharm.D., D.O. as Medical Director of Behavioral Health; Robin Hatam, D.O., Medical Director of Chronic and End-Stage Kidney Disease; and Claus Hecht, M.D., Medical Director of Street Medicine.

3. CalAIM Workforce Development Program Results

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, introduced Mark Loranger, Chief Executive Officer, Chrysalis, to share some of the innovative ways that CalOptima Health's CalAIM initiatives are assisting in workforce development.

Mr. Loranger provided background on Chrysalis and how funding through CalOptima Health's CalAIM initiative in workforce development is making a difference in the lives of members experiencing homelessness in Orange County. Mr. Loranger explained that Chrysalis is a workforce development

agency that is focused on getting people back to work. The people that Chrysalis serves, are ready, willing and able to go back to work, but they may not know quite how to do it because some of the barriers they faced in life. They may have been housing insecure; they may have had interactions with the criminal justice system or other recovery issues. That is where Chrysalis comes in and helps address those barriers. Through its five offices in Southern California, including in Anaheim and Orange, in Orange County, Chrysalis takes a trauma informed case management approach to make sure each of its clients is treated with respect, with dignity, and are able to achieve their own career goals. They map what they want to lay out for their life. Mr. Loranger added that most would agree that a job is much more than a paycheck. It means dignity, it means respect, and it means being able to reconnect with family and with the community. Mr. Loranger shared a video of Chrysalis workers at a Fullerton recuperative care and short term and emergency shelter run by the Illumination Foundation.

2. Update on Board Designated Reserve Levels

Nancy Huang, Chief Financial Officer provided an update on the Board-designated reserve analysis. Ms. Huang briefly reviewed the federal debt ceiling legislation, the Fiscal Year 2023-24 state budget, and the new 2024 Department of Health Care Services (DHCS) managed care contract requirements with the Board. Ms. Huang noted that CalOptima Health is not proposing any change in the Board-designated reserves policy as it aligns with 2024 DHCS managed care contract requirements.

PUBLIC COMMENTS

1. Dr. Pooja Bhalla, Illumination Foundation: Oral re: Thanking CalOptima Health for support of unhoused members.
2. Dr. Clark Lew, Illumination Foundation: Oral re: Thanking CalOptima Health and the importance of work being done in support of unhoused members.
3. Whitney Ayers, Hospital Association of Southern California: Oral re: Letter to the CalOptima Health Board of Directors and working together with the Orange County hospitals.
4. Shamiesha Ebhotemen, HERstory, Inc.: Oral re: Agenda Item 17 Approve Actions Related to Provision of Doula Services as a Covered Medi-Cal Benefit

CONSENT CALENDAR

4. Minutes

a. Approve Minutes of the August 3, 2023 Regular Meeting of the CalOptima Health Board of Directors and the Minutes of the June 29, 2023 Special Meeting of the CalOptima Health Board of Directors

5. Approve Modifications to CalOptima Health Policy GA.3202: CalOptima Health Signature Authority

6. Approve New CalOptima Health Policy GG.1630: Reporting Communicable Diseases

7. Authorize and Direct Execution of a new "Companion Contract" with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

8. Appointment to the CalOptima Health Board of Directors' Member Advisory Committee

9. Receive and File:

a. July 2023 Financial Summaries
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 4 through 9, as presented. (Motion carried 8-0-0)***

REPORTS/DISCUSSION ITEMS

10. Election of Officers of the Board of Directors for Fiscal Year 2023-24

James Novello, Outside General Counsel, Kennaday Leavitt, provided an update, noting that he has compiled a significant amount of data around public agencies in Orange County and how they conduct their elections, including the Board of Supervisors, and also looked at other similarly situated public agencies that provide medical benefits around the state on practices of other public agencies as it relates to election of officers and other Board governance items. Mr. Novello added his first recommendation would be to form an Ad Hoc around corporate governance where the Board can vet the information and decide how it wants to move forward not only with the election process but with other corporate governance matters that are in front of this Board.

After considerable discussion, the Board took the following action:

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors extended the Terms of the Current Chair and Vice Chair of the Board of Directors (Board) until the November 2, 2023 Board Meeting. (Motion carried; 5-2-1; Chair Corwin; Vice Chair Contratto; Directors Becerra, Mayorga and Tran voting yes; Supervisors Chaffee and Sarmiento voting no and Director García Guillén abstained)***

11. Approve Modifications to CalOptima Health Board-Designated Reserve Funds Policy

Ms. Huang briefly introduced this item.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors approved modifications to CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. (Motion carried; 8-0-0)***

12. Approve Modifications to CalOptima Health Office of Compliance Policy HH.3012: Non-Retaliation for Reporting Violations

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors approved updated Office of Compliance Policy HH.3012: Non-Retaliation for Reporting Violations. (Motion carried; 8-0-0)***

13. Approve Contract for State and Local Advocacy Services

Supervisor Sarmiento requested that staff provide additional details going forward with items that go out to bid, such as scoring sheets, which would be helpful to understand the decisions to move one vendor forward even though that vendor is a more expensive firm.

Back to Agenda

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute a contract with Strategies 360, Inc. (Strategies 360) for state and local advocacy services, effective October 1, 2023, through October 31, 2026. (Motion carried; 8-0-0)***

14. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Director Garica Guillen did not participate in this item due to potential conflicts of interest. Supervisor Sarmiento did not participate in this item in an abundance of caution due to possible campaign contributions under the Levine Act. Director Tran did not participate in this item due to his role as a Physician Specialist.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors: 1.) Ratified a temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians, except physicians employed by UCI Health or the University of California, Irvine, for the period of July 1, 2023, through August 31, 2024; 2.) Ratified contract amendments and policies and procedures that implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and 3.) Ratified unbudgeted expenditures from existing reserves in an amount up to $10.2 million to support the public health emergency transition supplemental payment program for all contracted fee-for-service physicians. (Motion carried; 5-0-0; Director García Guillén; Supervisor Sarmiento; and Director Tran recused)***

15. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Director Garica Guillen did not participate in this item due to potential conflicts of interest. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Supervisor Sarmiento did not participate in this item in an abundance of caution due to possible campaign contributions under the Levine Act.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Ratified the temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians employed by UCI Health or the University of California, Irvine for the period of July 1, 2023, through August 31, 2024; and 2.) Ratified contract amendments and policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases. (Motion carried; 5-0-0; Director García Guillén; Director Mayorga; and Supervisor Sarmiento recused)***

16. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds

Back to Agenda

Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2022
Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health and Supervisor Sarmiento did not participate in this item in an abundance of caution as the County of Orange is one of the funding partners.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors authorized the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2022 (IGT 12): 1.) Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in IGT 12; 2.) Pursuit of funding partnerships with the University of California-Irvine, First 5 Orange County (Children & Families Commission), the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach to participate IGT 12; and 3.) Authorized the Chief Executive Officer to execute agreements with these entities and their designated providers (as necessary) to seek IGT 12 funds. (Motion carried 6-0-0; Director Mayorga recused, and Supervisor Sarmiento abstained)***

17. Approve Actions Related to Provision of Doula Services as a Covered Medi-Cal Benefit
After hearing public comment on this item, the Board took the following action:

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized implementation of new Medi-Cal Ancillary Services Contract template for doula services, effective September 1, 2023; and 2.) Authorized reimbursement for doula services at 100% of the CalOptima Health Medi-Cal Fee Schedule. (Motion carried 8-0-0)***

18. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2024

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision, for CalOptima Health employees and eligible retirees (and their dependents); basic life, accidental death and dismemberment (ADD), short-term disability (STD) and long-term disability (LTD) insurance; an employee assistance program; and flexible spending accounts (FSA) for Calendar Year (CY) 2024 in an amount not to exceed $32.0 million, which includes the following recommended program updates with estimated cost changes: a.) The renewal of the current Blue Shield of California Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plan, PPO Savings High Deductible Health Plan (HDHP), Blue Shield of California Dental HMO and PPO plans, Kaiser Permanente (Kaiser) HMO, Kaiser Senior Advantage, AmWins Retiree Medicare Supplement Plan, VSP vision, New York Life Basic Life/ADD, STD, LTD, Aetna Resources for Living Employee Assistance***

Back to Agenda

Program (EAP), and Wex Flexible Spending Account (FSA) plans and COBRA administration with no changes in plan designs; b.) An increase in employer contributions for active and retiree medical plans of 7.9% or $2,159,825 from CY 2023 due to an overall rise in premium rates. The total employer contribution for CY 2024 is $24,519,676. The total employee contribution will remain unchanged from CY 2023; c.) An increase in employer contributions of 28.0% or $73,150 from CY 2023 to fund the Health Savings Accounts (HSA) for employees anticipated to enroll in the Blue Shield PPO Savings HDHP. The total employer contribution for CY 2024 is $334,400; d.) The elimination of the spousal surcharge imposed on employees who cover a spouse who has access to alternative group health plans. The total net fiscal impact to CalOptima Health is $247,200 in CY 2024; e.) The addition of $51,000 in funding to offer on-site and virtual counseling and mental health services through Aetna Resources for Living EAP; and 2.) Authorized the receipt and expenditures for CalOptima Health staff wellness programs of $75,000 in funding from Blue Shield of California for CY 2024. (Motion carried 8-0-0)

19. Authorize Action Related to California Public Employees' Retirement System Unfunded Accrued Liability

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to execute a one-time additional discretionary payment of $49,999,717 to fully fund the California Public Employees' Retirement System Unfunded Accrued Liability balance as of June 30, 2022. (Motion carried 8-0-0)***

As noted at the top of the agenda, the Board will hear Agenda Item 20 after Closed Session.

ADVISORY COMMITTEE UPDATES

21. Regular Joint Meeting of the Member Advisory Committee and Provider Advisory Committee Update

Maura Byron, Chair of the Member Advisory Committee (MAC) updated the Board on recent activities at the Joint Meetings of the MAC and the Provider Advisory Committee.

CLOSED SESSION

The Board adjourned to Closed Session at 4:21 p.m. pursuant to Government Code Section 54956.8, CONFERENCE WITH REAL PROPERTY NEGOTIATORS, Under Negotiation: Price and terms of payments, Property: 7900 Garden Grove ~~Avenue~~ Boulevard, Garden Grove, CA 92841, Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Lvt, Inc. and pursuant to Government Code Section 54956.9(d)(1), CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION.

Rev. 9/22/23

The Board returned to open session at 5:02 p.m. and the Clerk re-established a quorum.

Back to Agenda

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Debra Baetz (non-voting); Isabel Becerra; Supervisor Doug Chaffee; Norma García Guillén; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento; Trieu Tran, M.D.

(All Board members in attendance participated in person)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

CLOSED SESSION

CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8
Under Negotiation: Price and terms of payments
Property: 7900 Garden Grove ~~Avenue~~ Boulevard, Garden Grove, CA 92841
Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Lvt, Inc.

Rev. 9/22/23

Mr. Novello, Outside General Counsel, Kennaday Leavitt, read the following action taken in Closed Session for item CS-1:

Action: ***On motion of Supervisor Sarmiento, seconded by Chair Corwin, the Board of Directors has unanimously voted to approve the acquisition of the property at 7900 Garden Grove ~~Avenue~~ Boulevard, Garden Grove, California 92841 for a purchase price of $8 million. (Motion carried 8-0-0)***

Rev. 9/22/23

CS-2. CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION Pursuant to Government Code Section 54956.9(d)1

Chair Corwin noted for the record that there was no reportable action taken in Closed Session for item CS-2.

20. Approve Actions Related to the Garden Grove Street Medicine Pilot Program and Support Center

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO) to: a.) Solicit, select and contract for general contractor services and furniture, fixtures, and equipment for the Street Medicine Support Center at 7900 Garden Grove Boulevard, Garden Grove, California; b.) Execute a contract amendment with Totum Corporation to complete full scope design, including assessments, architecture and engineering, project management, local engagement, permits, and fees for the Street Medicine***

Back to Agenda

Support Center at 7900 Garden Grove Boulevard, Garden Grove, California for the nine-month period of September 1, 2023, through May 31, 2024; c.) Execute a contract amendment with RiverRock Real Estate Group, Inc. (RiverRock) for property management, maintenance and security services at 7900 Garden Grove Boulevard for the nine-month period of September 1, 2023, through May 31, 2024; 2.) Authorized unbudgeted expenditures in an amount up to $10.51 million in undesignated reserves to fund the Recommended Action 1; 3.) Authorized the CEO to negotiate an amendment to the existing contract with Healthcare in Action to include additional services to be provided at the Street Medicine Support Center; and 4.) Made exceptions to CalOptima Health Policy GA.5002: Purchasing Policy related to Recommended Actions 1b, 1c, and 3. (Motion carried 8-0-0)

Ms. Kim thanked the Board for its support of the Garden Grove Street Medicine Support Center.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Supervisor Chaffee commented regarding the ad hoc committee on Corporate Governance, stating that he does not want to be on the ad hoc committee but would like to make two suggestions. One, the election should be conducted by a neutral party. He noted that almost universally and on other boards that he sits on, they use legal counsel to run the election and take it out of the hands of the people who might be elected. Another possibility would be to have the Clerk of the Board run the election. Supervisor Chaffee also suggested that an easier way to draft Board rules is to adopt something like Robert Rules of Order, the Board would need to read through the Robert Rules of Order and could adopt portions of it. Supervisor Chaffee also reported that his office created a program for the Fullerton Police Department where they are hiring social workers to be a part of the department and hopefully de-escalate issues.

Vice Chair Contratto thanked Nancy Huang and her team for their due diligence on the CalPERS performance and the decision to fund unfunded employee retirement benefits.

ADJOURNMENT

Chair Corwin adjourned the meeting in a somber tone, sharing sad news that one of CalOptima Health's Information Technology Services (ITS) team members suddenly passed away two weeks ago. Phillip Marquez, III was a valued member of the Service Desk team for over six years and always had a passion for helping others. On behalf of the Board, Chair Corwin offered the Board's sincere condolences to Phillip's family, his four children, the ITS team and everyone at CalOptima Health who had the privilege of working with him.

Back to Agenda

Hearing no further business, Chair Corwin adjourned the meeting in memory of Phillip Marquez, III at 5:15 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 5, 2023

Back to Agenda

MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
FINANCE AND AUDIT COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 22, 2023

A Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee (FAC) was held on March 22, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023.

Chair Isabel Becerra called the meeting to order at 3:01 p.m., and Director Corwin led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Clayton Corwin (All members participated in person)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Nancy Huang, Chief Financial Officer; Yunkyung, Kim, Chief Operating Officer; Zeinab Dabbah, M.D., Ph.D., Deputy Chief Medical Officer; Troy Szabo, Outside General Counsel; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer (CFO), provided two updates during her Chief Financial Officer (CFO) report. The first update was regarding Governor Newsom's May budget revise, also known as the May Revise. Governor Newsom released the May Revise on May 12, with California's state budget totaling more than $300 billion dollars. Ms. Huang noted the budget includes an additional $9.3 billion deficit from the Governor's January estimate. She also noted that the Governor's budget maintains funding for expansion of full scope Medi-Cal to all income eligible individuals regardless of citizenship status and continues the administration's commitment to CalAIM and other homelessness-related programs. Ms. Huang added that CalOptima Health has factored in most of those changes in its budget development for Fiscal Year (FY) 2023-24.

Ms. Huang stated that the second update was on CalOptima Health's total net asset analysis. She reviewed CalOptima Health's total net assets of $1.5 billion as of March 31, 2023. Ms. Huang explained that the $1.5 billion total is allocated into four different categories. The first category is Board-designated reserve funds, currently at $578 million, which also included $100 million for the minimum tangible net equity requirements as mandated by the Department of Managed Health Care. Ms. Huang noted that CalOptima

Back to Agenda

Health's Board-reserve policy is to maintain reserves of between 1.4 to 2 times its monthly revenue. The $578 million Board-reserve is equal to about 1.85 times CalOptima Health's monthly revenue. The second category is capital assets. CalOptima Health currently has $67.1 million in fixed capital assets, which includes building, equipment, furniture, and other fixed assets. The third category is funds that the Board has approved for various initiatives, which currently totals $441.4 million. Ms. Huang noted that these initiatives include housing and homelessness programs, equity programs, and quality programs to support CalOptima Health's members and providers. The fourth category is unallocated reserves, which is currently at $455.7 million dollars. This is the category under which staff will bring actions to the Board for consideration for various initiatives that serve members and the community to enable a healthier Orange County.

Ms. Huang also reviewed the reserve levels of other health plans in California in comparison to CalOptima Health. She also reviewed the various reserve levels for CalOptima Health in current 1.4 to 2.0 months in reserves as well as what 3 months in reserves would look like should the Board decide to increase its Board-designated reserve policy.

Michael Hunn, Chief Executive Officer, added that CalOptima Health will bring several initiatives forward for the Board to approve which will reduce the current unallocated reserves.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that CalOptima Health has experienced zero major cybersecurity incidents; however, he added that it has received notifications from five of its vendors that experienced major cybersecurity incidents. Mr. Steele reviewed the commonly used attack vectors, which include email attacks, malicious files, patch or configuration exploit, weak credentials, and ransomware/exfiltration.

Mr. Hunn added that those who exploit individuals and organizations are always looking for ways to get into an individual's account or an organization's account. These attacks are getting more and more sophisticated, which is why CalOptima Health goes through monthly trainings on what to look for and to not be fooled into providing information or clicking on links even when the email is from someone with whom you regularly do business.

Mr. Steele also noted that CalOptima Health is adding the following tools to close known gaps in security: Privileged Account Management Solution, which limits the risk around administrator and service accounts that traditionally have elevated privileges and are a target for attackers; Zero Trust Network Architecture (ZTNA), which will limit the risk through virtual private network (VPN) firewalls or compromised devices and will microsegment CalOptima Health's applications for an additional security layer; and Asset Management and Patch/Vulnerability remediation, which provides visibility to CalOptima Health IT assets and automates remediations for known vulnerabilities.

Mr. Steele responded to Board member questions.

Wael Younan, Chief Information Officer, thanked Mr. Steele for the thorough cybersecurity update and added that due to the ever-changing security risks, CalOptima Health has assessed the tools it previously used and made decisions to add the tools above to be able to get ahead of the risks as best as possible. Mr. Younan noted that nothing is 100% secure, but with the new tools and continued due diligence and staff training, CalOptima Health is in a much more secure position to protect the agency and its members.

Back to Agenda

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of January 1, 2023, through March 31, 2023. The portfolio totaled approximately $3 billion as of March 31, 2023. Of this amount, $2.5 billion was in CalOptima Health's operating account, and $577 million was included in CalOptima Health's Board-designated reserves. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the March 9, 2023 Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the January 23, 2023 Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

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

REPORT ITEMS

5. Recommend Board of Directors Approval of the CalOptima Health Fiscal Year 2023-24 Operating Budget and Non-Operating Items

Mr. Hunn provided introductory comments regarding CalOptima Health's FY 2023-24 operating and non-operating budget items. He noted that being here at CalOptima Health is a great privilege and noted that CalOptima Health serves almost a million people in Orange County. Mr. Hunn added that CalOptima Health could not provide health care to its members without its networks of care, its doctors, nurses, caregivers, doctor offices, diagnostic offices, skilled nursing facilities, pharmacies, acute care facilities, hospitals, community clinics, transportation providers and other providers. This budget, Mr. Hunn commented, is reflective of CalOptima Health being better together and administering these funds for the good and the health and the well-being of its members and the community.

Ms. Huang reviewed the details of the FY 2023-24 operating budget and non-operating budget items, starting on slide 12 of the presentation, noting that enrollment is the number one driver for both revenue and expenses. She noted that CalOptima Health projected a high of over 1 million members in calendar year 2023; however, by the end of FY 2023-24 the projected membership drops to 810,000 individuals. The projected drop in membership is partly due to redetermination and the transition of 55,000 members to Kaiser, but it also considers an increase of approximately 45,000 members due to Medi-Cal adult expansion regardless of their immigration status. Ms. Huang noted that CalOptima Health's projected revenue for FY 2023-24 is approximately $4 billion dollars.

Ms. Huang reviewed the medical-related costs projected for FY 2023-24, noting that staff is projecting higher medical costs as utilization trends return to pre-COVID levels. She noted that in total CalOptima Health is projecting that 94% of its revenue will go to medical costs, which includes provider capitation, claims payments including long-term care/skilled nursing facilities, prescription drugs, professional, facility

and other ancillary costs, case management and other medical costs. Ms. Huang noted that CalOptima Health's projected medical costs are approximately $3.8 billion dollars.

Ms. Huang reviewed the administrative expenses in detail and noted that CalOptima Health's projected administrative expenses are approximately $214 million for FY 2023-24. She noted that CalOptima Health's operating income/margin is projected to be approximately $17 million or 0.44%.

Ms. Huang reviewed the Medi-Cal rebasing results, which CalOptima Health used its consultant Milliman, to review and recalibrate its base capitation rates paid to health networks. She reviewed the aid codes for facility, professional, and the combined rates.

Ms. Huang and Mr. Hunn reviewed the budget in detail and responded to the FAC member questions.

After considerable discussion, the FAC took the following action:

Action: ***On motion of Director Contratto, seconded and carried, the Committee Recommended that the Board of Directors: 1.) Approve the CalOptima Health Fiscal Year 2023-24 Budget, as reflected in Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items; and 2.) Authorize the expenditures and appropriate the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing. (Motion carried 3-0-0)***

6. Recommend Board of Directors Approval of the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets

Ms. Huang reviewed the FY 2023-24 Routine Capital Budget, which totals $14,741,000 and includes $1,705,500 in Information Technology Services (ITS), $3,568,000 in improvements for the 505 City Parkway West building, $8,850,500 in improvements for the 500 City Parkway West building, and $617,000 in improvements at the PACE building.

Ms. Huang reported that the Capital Budget for year two for the Digital Transformation Strategy is projected to be $20,987,000. She noted that the total Capital Budget for FY 2023-24 is $35,728,000.

Director Contratto asked if staff could highlight in the Fast Facts that CalOptima Health Customer Service calls are attributed to administrative loss ratio not the medical loss ratio.

Ms. Huang and Mr. Hunn responded to FAC member questions and after considerable discussion, the FAC took the following action:

Action: ***On motion of Director Corwin, seconded and carried, the Committee Recommended that the Board of Directors: 1.) Approve the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets; and 2.) Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Health Board-approved policies: a.) Attachment A: Fiscal Year 2023-24 Routine Capital***

Budget by Project; and b.) Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project. (Motion carried 3-0-0)

7. Moss Adams 2023 Financial Audit Planning

Ms. Huang introduced independent auditor Moss Adams' audit engagement partner, Aparna Venkateswaran, who provided a brief overview of the audit planning process and introduced audit senior manager Ashley Merda. Ms. Merda reviewed the significant audit areas that Moss Adams will be reviewing, which include medical claims liability and claims expense, capitation revenue and receivables, amounts due to the State of California or the Department of Health Care Services (DHCS). Ms. Merda reviewed the timeline for this audit for the FY ending June 30, 2023, noting that Moss Adams' staff met with CalOptima Health management back in March to discuss the financial audit plan. In July, Moss Adams will return to start the final fieldwork procedures with the goal of wrapping up and presenting the audit results at the September 21, 2023, FAC meeting.

8. CalOptima Health Rebasing Process and Result Overview

Ms. Huang, Mr. Hunn, and Yunkyung Kim, Chief Operating Officer, reviewed the CalOptima Health rebasing process and result overview during the budget presentations. Consultants from Milliman were also available online for any questions. Ms. Huang thanked Milliman for all their work during this year's rebasing efforts.

The following items were accepted as presented.

9. March 2023 Financial Summary

10. Quarterly Operating and Capital Budget Update

11. Quarterly Reports to the Finance and Audit Committee

a. Shared Risk Pool Performance
b. Whole-Child Model Financial Report
c. Enhanced Care Management Financial Report
d. Reinsurance Report
e. Health Network Financial Report
f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

The FAC members thanked staff for the work that went into the CalOptima Health FY 2023-24 budgets and the transparency of the public dollars that fund the Medi-Cal and Medicare programs.

Back to Agenda

ADJOURNMENT

Hearing no further business, FAC Chair Becerra adjourned the meeting at 5:14 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 21, 2023

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Authorize Actions Related to Emergency Repair for CalOptima Health Facility

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

1. Authorize an emergency repair at CalOptima Health facility located at 500 City Parkway West in Orange (500 Building) by making an exception to CalOptima Health Policy GA.5002: Purchasing Policy.

Background

CalOptima Health owns a four-story commercial office building located at 500 City Parkway West in Orange, California with floors occupied by CalOptima Health staff and tenants. CalOptima Health is responsible for ensuring that the facilities are secure, clean, and fully operational in order to safely accommodate the needs of employees, members, visitors, and tenants.

The 500 Building has two (2) DX air handlers. At the time the building was purchased, the original engineering report recommended the replacement of one (1) air handler. Staff proceeded with plans to replace both air handlers over a two (2)-year period.

As such, the Fiscal Year (FY) 2022-23 CalOptima Health Routine Capital Budget approved by the CalOptima Health Board of Directors (Board) on June 2, 2022, included $650,000 under the category, 500 Building Improvements for the project, "HVAC Equipment Replacement." In accordance with CalOptima Health's Purchasing Policy, a request for proposal to replace one (1) DX air handler was completed, with the contract awarded to Mesa Energy Systems, Inc. The contract was executed on August 23, 2023.

The FY 2023-24 CalOptima Health Routine Capital Budget approved by the Board on June 2, 2023, included $650,000 under the category, 500 Building Improvements for the project "HVAC Equipment Replacement," to replace the second air handler in the current fiscal year.

Discussion

During the past several months of operations at the 500 Building, CalOptima Health's building engineer notified staff of operational issues related to the second air handler and recommended immediate replacement.

Staff would like to amend the contract with Mesa Energy Systems, Inc. to replace the second air handler for the following reasons:

- Best interest to CalOptima Health and value: Staff believes it is in the best interest of CalOptima Health to order the second air handler as soon as possible. On average, it will take approximately

Back to Agenda

forty-two (42) weeks to complete the order. Staff will negotiate a fair and competitive price with the vendor. By using a single entity, this vendor will be able to address the technical and mechanical issues of integrating the two separate air handlers at the same time.

- Gain economies of scale: By replacing both air handlers at the same time, CalOptima Health will reduce costs by avoiding redundant tasks (*e.g.*, paying for re-piping on the second air handler one time instead of twice), and by allowing the vendor to mobilize equipment and crews efficiently. In addition, it will also decrease the length of time and number of disruptions to operations at the 500 Building and surrounding areas.

Upon Board authorization to make an exception to CalOptima Health Policy GA.5002: Purchasing Policy, staff will negotiate the fair and competitive price for the second air handler within the budgeted amount approved by the Board on June 2, 2023. By amending the contract with Mesa Energy Systems, Inc., CalOptima Health will ensure continuity of service, compatibility with the new equipment, and the protection and security of CalOptima Health's building, its employees, members, visitors, and tenants.

Fiscal Impact
The recommended action is a budgeted item.

Rationale for Recommendation
The recommended action will protect CalOptima Health's property and assets and provide a secure and professional work environment for employees and tenants and a safe environment for CalOptima Health's members and visitors.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Mesa Energy Systems, Inc.	2 Cromwell	Irvine	CA	92618

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Authorize Actions Related to Permanent Supportive Housing Pilot Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal & CalAIM, (714) 954-2140

Recommended Actions

Authorize the Chief Executive Officer to enter into a Memorandum of Understanding (MOU) with Orange County Community Resources/OC Housing & Community Development (OCCR/OCHCD), and Jamboree Housing for the creation of a pilot program to evaluate the delivery of CalAIM supportive services for persons exiting homelessness through the coordinated entry system.

Background and Discussion

On January 1, 2022, the Department of Health Care Services (DHCS) implemented the 5-year CalAIM program that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Key to this program are several community supports geared to aiding unhoused individuals to identify, secure, and retain housing.

Through the execution of the MOU, OCCR/OCHCD, Jamboree Housing, and CalOptima Health desire to design a pilot program that is intended to demonstrate and evaluate the feasibility of using CalAIM reimbursement for CalAIM services to meet the service needs and obligations to the residents of affordable supportive housing developments and more effectively leverage other existing sources. The three Jamboree Housing managed permanent supportive housing projects proposed to be used for the pilot are Ascent Apartment Homes in Buena Park, Huntington Beach Senior Apartment Homes in Huntington Beach, and Clear Vista (formerly Tahiti Apartment Homes) in Stanton.

All parties to the MOU agree that it is in the best interests of those persons experiencing homelessness, who are mutually served by the parties, to better align funding resources where feasible to reduce the subsidy required for the housing type that can then be utilized to develop additional supportive housing.

Specifically, Jamboree Housing, OCCR/OCHCD, and CalOptima Health agree to, over a two-year period, assess the effectiveness of Jamboree Housing in accessing CalAIM resources to serve the residents at the aforementioned permanent housing developments, enrolling and maintaining enrollment of all qualified individuals on a voluntary basis for the CalAIM services, and ensuring CalOptima Health members referred for this pilot are not receiving duplicative services. The pilot aims to demonstrate higher housing retention when CalAIM services are offered consistently while members are enrolled in one of the three identified pilot permanent supportive housing locations.

Staff will return to the Board with additional information on the pilot program, including cost and utilization estimates, at a future meeting.

Back to Agenda

Fiscal Impact
The recommended action to enter into an MOU with OCCR/OCHCD and Jamboree Housing has no fiscal impact.

Rationale for Recommendation
CalOptima Health, OCCR/OCHCD, and Jamboree Housing share common goals of improving housing and health outcomes for residents of Orange County who are experiencing homelessness. Staff believes that the partnership described in the MOU will be beneficial for unhoused CalOptima Health members and could ensure members, once placed into the pilot program, could reduce their risk of returning to homelessness.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Draft OCCR/OCHCD and Jamboree Housing Memorandum of Understanding

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Medical Group	Address	City	State	Zip Code
County of Orange OC Community Resources/OC Housing & Community Development		1501 E St. Andrew Place	Santa Ana	California	92705
Jamboree Housing Corporation		17701 Cowan Ave Suite 200	Irvine	California	92614

Back to Item

Back to Agenda

Memorandum of Understanding
Between
County of Orange
OCCR/OCHCD, CalOptima
Health and
Jamboree Housing Corporation

General Provisions

This Memorandum of Understanding effective as of ____(DATE)_____ expresses the intentions and goals between County of Orange, OC Community Resources/OC Housing & Community Development ("OCCR/OCHCD"), CalOptima Health ("CalOptima") and Jamboree Housing Corporation, a California nonprofit public benefit corporation ("Jamboree"), for the creation of a pilot program to evaluate the delivery of supportive services for persons exiting homelessness through the Coordinated Entry System using CalAIM-funded services in permanent supportive housing developments.

Intent

This pilot program is intended to demonstrate and evaluate the feasibility of using CalAIM reimbursements for CalAIM services to meet the service needs and obligations to the residents of affordable supportive housing developments and more effectively leveraging other existing sources.

The three projects developed and managed by Jamboree (referred to as "the Developments"), proposed to be used as the pilot study for this evaluation of CalAIM funded services are:

1. Ascent Apartment Homes, Buena Park
2. Huntington Beach Senior Apartment Homes, Huntington Beach
3. Clara Vista (formerly Tahiti Apartment Homes), Stanton

The parties agree the goal is to use scarce resources most efficiently to provide capital and operating subsidies for supportive housing developments. CalAIM services refers only to the Community Supports "Housing Tenancy Sustaining Services."

This document is intended to express the interest and commitment of the parties to evaluate a sustainable services model delivered by Jamboree, as a CalOptima Medi-Cal enrolled CalAIM provider, with the support and agreement of CalOptima and OCCR/OCHCD consistent with all housing finance loan documents, regulatory agreements and other applicable requirements with respect to each Development and all applicable federal Medicaid/Medi-Cal guidelines and California Department of Health Care Services regulatory requirements regarding CalAIM services.

The pilot study articulated by this MOU would benefit residents to be housed in the Developments referenced above and funded in part by OCCR/OCHCD, owned by an affiliate of Jamboree for CalOptima Health members eligible for the CalAIM benefits.

The parties to this MOU agree that it is in the best interests of those persons experiencing homelessness, who are mutually served by the parties, to better align funding resources

Back to Item
Back to Agenda

where feasible to reduce the subsidy required for this housing type that can then be utilized to develop additional supportive housing.

By Signing this MOU

All Parties agree to:

Meet formally once every 90 days during the term of this MOU commencing on 90 days following the execution of this MOU.

Jamboree agrees to:

1. Assess, in partnership with OCCR/OCHCD and CalOptima over a two-year period, the effectiveness of Jamboree in successfully and continuously accessing CalAIM resources to serve the residents at the Developments.

2. Assist qualified households residing in the Developments on a voluntary basis to enroll as CalOptima Health members and for the CalAIM Services.

Use commercially reasonable efforts to ensure that qualified households residing in the Developments are enrolled in CalAIM Services. CalOptima Health members referred for residency in the Developments will be evaluated to ensure they are not also receiving duplicative services funded by No Place Like Home, Mental Health Services Act (services provided through OC Health Care Agency) or Veterans Affairs Supportive Housing,(services provided through the Veterans Administration) or in general, units already receiving services from another agency. OCCR/OCHCD agrees to:

1. Assess, in partnership with Jamboree and CalOptima over a two-year period, the effectiveness of Jamboree in successfully and continuously accessing CalAIM Services to serve the residents at the Developments.

2. Cooperate with Jamboree and CalOptima to assess periodically on a timely basis the effectiveness of the pilot at the Developments and provide formal feedback as to the satisfactory performance of the pilot in meeting the intent of this agreement.

3. Work in good faith with Jamboree to review and respond to proposed changes in existing agreements that may be requested by Jamboree or their Lenders and Investors to implement the pilot program, so long as the proposed changes are in accordance with adopted County policy and/or Board of Supervisors approval.

CalOptima Health agrees to:

1. Assess, in partnership with OCHCD and Jamboree over a two-year period, the effectiveness of Jamboree in successfully and continuously accessing CalAIM Services to serve the residents at the Developments.

2. Jointly commit to continuously reviewing the success at reaching 100% of eligible

enrollments in CalAIM Services at the Developments.

3. Demonstrate a flexible and adaptable approach to ensuring, within the limits of federal and state law and Medi-Cal regulatory requirements, to assist in the effective implementation of this pilot.

4. Adopt a presumption of eligibility for CalAIM services, to be articulated in a separate document, for those persons/households referred to these pilot sites for residency. The intent of this pilot is to evaluate the feasibility of the adoption of a lifetime eligibility for the identified CalAIM services as long as the CalOptima Health member remains housed in Permanent Supportive Housing.

TERM and EXPIRATION

This MOU shall be effective as of the date of signature and shall continue thereafter until two years from the date of signature. Prior to the expiration of this agreement two years from date of signature the agreement will continue until, upon notification of any party to this agreement, with 30 days written notice the agreement may be terminated.

AGREED AND ACCEPTED:

COUNTY OF ORANGE
OC Community Resources/OC Housing & Community Development

By: _____ Date: _____, 2023
Name:
Title:

APPROVED AS TO FORM
COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy

CalOptima Health

By: _____ Date: _____, 2023
Name:

Back to Item

Back to Agenda

Title:

Jamboree Housing Corporation,
a California nonprofit public benefit corporation

By: _____ Date: _____, 2023
Name:
Title:

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve Actions Related to CalOptima Health Street Medicine Program

Contacts

Marie Jeannis, R.N., Executive Director, Population Health Management, (714) 246-8591
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM Operations Management, (657) 550-4741

Recommended Actions

1. Authorize reallocation of 11,053 nonmonetary gift cards totaling $276,652 from the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy to the CalOptima Health Street Medicine Program to provide up to four (4) $25 non-monetary gift cards to members that complete initial or follow-up visit(s).

Background

In January 2021, the CalOptima Board of Directors (BOD) authorized the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy, which allocated $400,000 to provide two (2) nonmonetary gift cards to members experiencing homelessness who received the required doses of COVID-19 vaccine. In December 2021, the CalOptima BOD authorized extension of the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy through Calendar Year 2022.

The non-monetary gift cards were distributed through CalOptima Health partnerships with federally qualified health centers and the Orange County Health Care Agency. CalOptima Health staff purchased 13,200, $25 nonmonetary gift cards based on unsheltered member estimates at the time of purchase. As of April 1, 2022, there were a total of 2,147 gift cards distributed with 11,053 remaining in inventory.

The distribution of gift cards was impacted by COVID-19-related challenges, which included reduced clinic staff and closed shelters for extended periods of time due to outbreaks. Many unhoused members may have received the single-dose Janssen vaccine, and therefore one gift card was distributed per the program. Additionally, due to the transitory nature of members experiencing homelessness, unhoused members may have passively received gift cards through the CalOptima Health Vaccine Incentive Program. CalOptima Health estimates that approximately 48% of unhoused members received at least one dose of the COVID-19 vaccine.

Discussion

In April 2023, CalOptima Health launched the Street Medicine program. This program is part of the larger, comprehensive approach to care for members experiencing homelessness, which includes outreach and engagement, coordinated medical care that meets members where they are, and comprehensive care coordination and community supports. To encourage completion of initial or follow-up visits, staff recommends reallocating cards from the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy and providing one (1) $25 non-monetary gift card per visit,

Back to Agenda

with a maximum of four (4) gift cards per Street Medicine program participant. The non-monetary gift cards will also be available to new program participants as the program expands to new cities.

Fiscal Impact
The recommended action has no additional fiscal impact to the CalOptima Health 2023-24 Operating Budget approved by the Board on June 1, 2023, as the number of gift cards distributed to eligible members will not exceed the total number of gift cards available.

Rationale for Recommendation
CalOptima Health staff believes the non-monetary gift cards have the potential to help build trust between members experiencing homelessness and the Street Medicine program team, encourage members to complete initial or follow-up visits, and facilitate member access to health care and housing.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic	1 year	$400,000
December 20, 2021	Consider Extending the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy for Calendar Year 2022	1 year	$400,000

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action to be Taken October 05, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Adopt Resolution No. 23-1005-01 Approving the Revised 2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan; and the 2024 CalOptima Health HIPAA Privacy and Security Program, and the Revised CalOptima Health Office of Compliance Policies and Procedures.

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Actions

1. Adopt Resolution No. 23-1005-01 approving the revised *2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste*, *and Abuse Plan; and the 2024 CalOptima Health HIPAA Privacy and Security Program*; and
2. Approve revised CalOptima Health Office of Compliance policies and procedures.

Background

CalOptima Health is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its federal and state health care program requirements. As part of that commitment, the CalOptima Health Board of Directors (the "Board") is annually presented with CalOptima Health's Compliance Program and associated documents for review and approval. The *2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and 2024 CalOptima Health HIPAA Privacy and Security Program*, comprehensively address the fundamental elements necessary for an effective compliance program, including those elements identified by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS).

Compliance Program Elements

Federal laws and regulations (including the CMS Medicare Advantage regulations) and OIG compliance guidance require that compliance programs be reasonably designed, implemented, and enforced to ensure the programs are effective in preventing, detecting, and correcting violations of standards or laws. CalOptima Health's Compliance Program addresses each of the seven fundamental elements of an effective Compliance Program, in addition to FWA prevention, detection, and remediation.

Written Standards

As part of its Compliance Program, CalOptima Health develops, maintains and distributes to its Board, employees and first tier, downstream or related entities (FDRs) written standards in the form of the *2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan; 2024 CalOptima Health HIPAA Privacy and Security Program* and written policies and procedures, as further detailed in the *2024 CalOptima Health Compliance Plan*. The *2024 CalOptima Health Compliance Plan* incorporates all the elements of an effective Compliance Program, as recommended by the OIG and required by CMS regulations. The

Back to Agenda

Compliance Program also includes a comprehensive anti-FWA plan, which establishes guidelines and procedures designed to prevent, detect, and remediate FWA in CalOptima Health programs.

Oversight
As CalOptima Health's governing body, the Board is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the Chief Executive Officer, who then delegates to the Chief Compliance Officer, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Chief Compliance Officer, in conjunction with the Compliance Committee, is accountable for the oversight and reporting roles and responsibilities set forth in the *2024 CalOptima Health Compliance Plan.* The Delegation Oversight Committee, a subcommittee of the Compliance Committee, is responsible for overseeing delegated activities.

Training and Education
Utilizing web-based courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and education regarding CalOptima Health's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles within CalOptima Health's departments and programs. Upon appointment, hire, or commencement of a contract, and annually thereafter, the Board, employees, and FDRs receive *CalOptima Health's Code of Conduct* and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements.

Effective Lines of Communication and Reporting
CalOptima Health utilizes various methods to communicate general information, regulatory updates, and process changes from the Chief Compliance Officer to the Board, employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form about how to identify, report, and prevent compliance issues and FWA. The Board, employees, FDRs, and/or members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected or actual non-compliance issues and FWA incidents through one of CalOptima Health's multiple reporting mechanisms. The reporting options provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima Health maintains and supports a non-retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Enforcement and Disciplinary Standards
The Board, employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima Health's standards, requirements, or applicable laws, as specified in the Compliance Program documents and related policies and procedures, including, but not limited to, CalOptima Health's policies and procedures on Performance and Behavior Standards, Corrective Action Plans, and/or Sanctions. CalOptima Health implements consistent, timely, and effective enforcement of

standards when non-compliance or unethical behavior is determined, including any appropriate disciplinary action to address improper conduct, activity, and/or behavior.

Monitoring, Auditing and Identification of Risks
CalOptima Health has implemented and continues to implement comprehensive monitoring and auditing activities, which are performed by the Delegation Oversight Department and Internal Audit Department in conjunction with CalOptima Health contract owners and functional business owners responsible for ongoing monitoring. The purpose of CalOptima Health's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and federal and state laws, as well as applicable policies and procedures established to protect against non-compliance and potential FWA in CalOptima Health's programs. The *2024 CalOptima Health Compliance Plan* and related policies and procedures address the monitoring and auditing processes carried out by CalOptima Health.

Response and Remediation
Once a violation or offense has been detected or reported, CalOptima Health initiates all necessary steps to investigate, identify, and respond appropriately to the violation or offense and to prevent similar violations and offenses from occurring. As described in the *2024 CalOptima Health Compliance Plan*, CalOptima Health will conduct a timely and documented investigation and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its policies and procedures to prevent the same or similar violation or offense from occurring in the future.

Discussion
CalOptima Health regularly reviews its *Compliance Plan; Code of Conduct; Anti-Fraud, Waste, and Abuse (FWA) Plan*; and *CalOptima Health HIPAA Privacy and Security Program* to ensure current alignment with federal and state health care program requirements and laws, as well as CalOptima Health operations. CalOptima Health's Chief Compliance Officer has reviewed the *2024 CalOptima Health Compliance Plan*; *2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan*; *2024 CalOptima Health HIPAA Privacy and Security Program*; and Office of Compliance policies and procedures to ensure consistency with applicable federal and state health care program laws, regulations and/or guidance.

Summary of Changes
The *2024 CalOptima Health Compliance Plan*; *2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan;* and *2024 CalOptima Health HIPAA Privacy and Security Program* have been updated and revised as follows:

- The ***2024 CalOptima Health Compliance Plan*** contains edits to include contractors to the list of recipients of the compliance plan, reflect restructuring of the Audit and Oversight Department to the Internal Audit Department and the Delegation Oversight Department, including clarity to the division of responsibilities for each department. The plan includes clarification that the routine monitoring and auditing of CalOptima Health operations is to be conducted by the Internal Audit

Department, and the routine monitoring and auditing of FDRs is to be conducted by the Delegation Oversight Department. Organizational or significant systems changes are now part of the elements reviewed during an annual Compliance Risk Assessment. The updates also include minor grammatical changes.

- The ***2024 CalOptima Health Code of Conduct*** was updated to add an introductory message from the Chief Compliance Officer, highlight the Compliance and Ethics Hotline, and provide the Code of Conduct 12 Principles.

- The ***2024 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan*** contains edits to include contractors to the list of recipients, update FWA training to clarify identification of FWA in programs, and prescription drug utilization. Updates were made to include the review of All Plan Letters (APLs) and discussion of allegation and evidence collected with subject matter experts, as necessary, to the FWA Investigative Process. Minor grammatical edits and changes to the list of CalOptima Health policies and procedures through which the FWA plan is effectuated were also made.

- The ***2024 CalOptima Health HIPAA Privacy and Security Program*** was created to support CalOptima Health's employee understanding of the legal and ethical responsibility to preserve and protect the privacy, confidentiality, and security of all confidential information in accordance with current laws, policies, and procedures.

Policies and Procedures
Consistent with applicable federal and state health care program laws, regulations, and guidance, the Chief Compliance Officer, with the support of the Office of Compliance staff, has updated the related policies and procedures. The summary of changes, reflecting new policies, policies with substantive changes, and policies with non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes), is included as Attachment 6. New policies or policies with substantive changes are included as Attachment 7.

Fiscal Impact
The recommended actions have no anticipated fiscal impact. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima Health staff recommends that the Board approve and adopt the updated *2024 CalOptima Health Compliance Plan, 2024 CalOptima Health Code of Conduct, 2024 CalOptima Health Anti-Fraud, Waste, and Abuse Plan, the 2024 CalOptima Health HIPAA Privacy and Security Program* and related policies and procedures. The updated *2024 CalOptima Health Compliance Plan* will supersede CalOptima Health's *2023 Compliance Plan*, *2023 CalOptima Code of Conduct*, and *2023 CalOptima Health Anti-Fraud, Waste and Abuse Plan* approved on December 01, 2022.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 23-1005-01, Resolution Approving the *2024 CalOptima Health Compliance Plan, 2024 CalOptima Health Code of Conduct, 2024 CalOptima Health Anti-Fraud, Waste & Abuse Plan*, *2024 CalOptima Health HIPAA Privacy and Security Program* and revised Policies and Procedures
2. 2024 CalOptima Health Compliance Plan [Draft]
3. 2024 CalOptima Health Code of Conduct [Draft]
4. 2024 CalOptima Health Anti-Fraud, Waste & Abuse (FWA) Plan [Draft]
5. 2024 CalOptima Health HIPAA Privacy and Security Program [Draft]
6. Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures
7. Revised Office of Compliance Policies and Procedures (redlined and clean versions) [Drafts]

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 23-1005-01

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

APPROVING THE 2024 CALOPTIMA HEALTH COMPLIANCE PLAN, 2024 CALOPTIMA HEALTH CODE OF CONDUCT; 2024 CALOPTIMA HEALTH ANTI-FRAUD, WASTE, AND ABUSE (FWA) PLAN; 2024 CALOPTIMA HEALTH HIPAA PRIVACY AND SECURITY PROGRAM; AND REVISED OFFICE OF COMPLIANCE POLICIES AND PROCEDURES

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima Health, provides that the Board of Directors is the governing body of CalOptima Health, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima Health shall be exercised, its property controlled, and its business and affairs conducted by or under the direction of the Board of Directors; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima Health's operations consistent with all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima Health's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in CalOptima Health's operations; and

WHEREAS, the Board of Directors last reviewed and approved the CalOptima Health Compliance Program on December 1, 2022, including the Compliance Plan; Code of Conduct; Anti-Fraud, Waste, and Abuse (FWA) Plan; and related Office of Compliance policies and procedures; and

WHEREAS, the Board of Directors reviews the CalOptima Health Compliance Program documents on a periodic basis to ensure the CalOptima Health Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and the 2024 CalOptima Health HIPAA Privacy and Security Program.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance policies and procedures. A summary of the policies and procedures and changes is provided in Attachment 6 Summary of Proposed Actions for the Office of Compliance Policies and Procedures and attached to this resolution. The full policies are provided in Attachment 7 Revised Office of Compliance Policies & Procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the 2024 CalOptima Health Compliance Plan; 2024 CalOptima Health Code of Conduct; 2024 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and the 2024 CalOptima Health HIPAA Privacy and Security Program.

Back to Item

Back to Agenda

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima Health, this 5th day of October 2023.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Clayton M. Corwin, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Back to Item

Back to Agenda

Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
GA.7508p: CalOptima Health Policy and Procedure Review Process *Regulatory Affairs & Compliance, Policies and Procedures*	**A - NEW:** This new policy was created in alignment with the 2024 Department of Health Care Services (DHCS) Contract and outlines CalOptima Health's Policy and Procedure Review Process to develop, review, revise, and retire, and ensure Policies and Procedures comply with regulatory and contractual requirements in alignment with CalOptima Health's mission, and vision. **Program(s):** Administrative Department Point(s) of Contact: Tracy Weske; John Tanner	
HH.3023p: Information Sharing *Privacy*	**A - NEW:** This new policy was created in alignment with the interoperability and data sharing requirements as stated in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide, the CalAIM Enhanced Care Management Policy Guide, CalAIM Data Sharing Authorization Guidance, CalAIM D-SNP Policy Guide and CalAIM Population Health Management Policy Guide to establish CalOptima Health's process to share information with participating First Tier, Downstream, and Related Entities (FDRs), local health jurisdictions, and county and/or other public agencies for purposes of coordinating Medicare and Medi-Cal Covered Services between settings of care. **Program(s):** Medi-Cal; OneCare Department Point(s) of Contact: Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2005: Corrective Action Plan *Office of Compliance*	**B – REVISED:** This policy was updated to reflect timeframes established internally to allow for five (5) days from the formal Immediate Corrective Action Plan (ICAP) request to an internal department or First Tier, Downstream, or Related Entity (FDR) to provide a written plan to address or remediate the deficiency. establish milestones and benchmarks. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annabel Vaughn; Annie Phillips; John Tanner	
HH.2014: Compliance Program *Office of Compliance*	**B – REVISED:** This policy was updated to reflect the inclusion of the Anti-Fraud, Waste and Abuse Plan, and the HIPAA Privacy and Security Program as applicable documents included in the Compliance Program. The attachments section was updated to move publicly available documents to the reference section for version accuracy. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Annabel Vaughn; Annie Phillips; John Tanner	
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI *Privacy*	**B – REVISED:** This policy was updated to reflect a 24 hour deadline for reporting or notification of known or suspected Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI from time of discovery to and from CalOptima Health. The change in mode of reporting privacy breaches and incidents to DHCS via the DHCS Privacy Incident Reporting Portal was also added. Reporting to the CMS IT Service Desk within one (1) hour of initial discovery and associated internal steps and subsequent process for resolution update was added. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.4002: CalOptima Health Internal Oversight *Internal Audit*	**B – REVISED:** This policy was revised to reflect the restructuring of the Audit and Oversight Department to the Internal Audit Department, managing CalOptima Health Internal Operations and the Delegation Oversight Department's focus on routine monitoring and auditing of FDRs. Clarity was added regarding timing for risk assessments to be performed monthly/quarterly and at least annually as determined in the Annual Internal Audit and Monitoring Work Plan. Additional elements to functional areas to be monitored were updated to include those identified as having a potential high or medium risk through the Annual Risk Assessment. **Program(s):** Administrative Department Point(s) of Contact: Kevin Larson; John Tanner	
HH.4003: Annual Risk Assessment *Internal Audit*	**B – REVISED:** This policy was revised to reflect the restructuring of the Audit and Oversight Department to the Internal Audit Department, managing CalOptima Health Internal Operations and the Delegation Oversight Department's focus on routine monitoring and auditing of FDRs. **Program(s):** Administrative Department Point(s) of Contact: Kevin Larson; John Tanner	
HH.2029: Annual Compliance Program Effectiveness Audit *Regulatory Affairs & Compliance*	**C – RETIREMENT:** This policy was reviewed for retirement as there is not a requirement for a policy specific to the Compliance Program Effectiveness (CPE) audit. CalOptima will continue to perform this audit on an annual basis in accordance with Chapter 21, Medicare Managed Care Manual Chapter 21, 50.6.5. **Program(s):** OneCare Department Point(s) of Contact: Annie Phillips; John Tanner	

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive revisions for the CalOptima Office of Compliance, by department.

POLICY	DEPARTMENT
HH.1105: Fraud, Waste, and Abuse Detection	*Fraud, Waste, and Abuse*
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, and Abuse*
HH.5004: False Claims Act Education	*Fraud, Waste, and Abuse*
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	*Privacy*
HH.3003: Verification of Identity for Disclosure of Protected Health Information	*Privacy*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3008: Member Right to Request Confidential Communications	*Privacy*
HH.3009: Access by Member's Authorized Representative	*Privacy*
HH.3010: Protected Health Information (PHI) Disclosures Required by Law	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*
HH.3014: Use of Electronic Mail with Protected Health Information (PHI)	*Privacy*
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3022: Business Associates Agreements	*Privacy*

POLICY	DEPARTMENT
AA.1270: Certification of Document and Data Submissions	*Regulatory Affairs & Compliance*
AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process	*Regulatory Affairs & Compliance*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7505: Regulatory Liaison Responsibilities	*Regulatory Affairs & Compliance*
HH.2002: Sanctions	*Regulatory Affairs & Compliance*
HH.2007: Compliance Committee	*Regulatory Affairs & Compliance*
HH.2014: Compliance Program	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2020: Conducting Compliance Investigations	*Regulatory Affairs & Compliance*
HH.2022: Record Retention and Access	*Regulatory Affairs & Compliance*
HH.2023: Compliance Training	*Regulatory Affairs & Compliance*
HH.2028: Code of Conduct	*Regulatory Affairs & Compliance*
MA.9124: CMS Self-Disclosure	*Regulatory Affairs & Compliance*

Orange County Health Authority
dba CalOptima Health

~~2023~~ 2024 Compliance Plan

(Revised ~~December~~ September ~~2022~~2023)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

TABLE OF CONTENTS

Back to Item

Back to Agenda

Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person ~~relies on compliance.~~in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date policies and procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the ~~Board~~CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any ~~concern for~~fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation ~~without disclosing any~~. You can choose to report anonymously and no identifying information ~~if that is what you choose~~will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as ~~a~~the framework for compliance in your work at or with CalOptima Health.

THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. Code of Conduct, Written Policies and Procedures

2. Compliance Officer, Compliance Committee, High-Level Oversight

3. Effective Training and Education

4. Effective Lines of Communication

5. Well-Publicized Disciplinary Standards

6. Effective System for Routine Monitoring. Auditing, and Identification of Compliance Risks

7. Procedures and Systems for Prompt Response to Compliance Issues

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima Health makes this Compliance Plan available to the ~~CalOptima Health~~ Board ~~of Directors, Employees~~, employees, contractors, and FDRs. All ~~CalOptima Health~~ Board ~~of Directors, Employees,~~Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt ~~the~~ CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or with the approval of CalOptima Health, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, ~~below referencing these materials and FDRs~~, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

Back to Item

Back to Agenda

Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to ~~CalOptima Health~~ Board ~~of Directors, Employees~~Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, ~~Employees~~employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations ~~and~~or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, ~~or~~ the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on the CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks*. The Code of Conduct is approved by the ~~CalOptima Health~~ Board ~~of Directors~~ and distributed to Board Members, ~~Employees~~employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, ~~Employees~~employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to ~~CalOptima Health~~the Board ~~of Directors, Employees~~, employees, contractors, and FDRs. This Compliance

Back to Item

Back to Agenda

Plan also includes a comprehensive section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all ~~Employees~~employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, ~~Employees~~employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, ~~Employees~~employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her ~~Designee~~designee, will ensure that Board Members, ~~Employees~~employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

~~The~~CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key ~~Management~~management staff, ~~meets~~ regularly ~~to review~~reviews, and ~~approve~~approves proposed changes ~~and additions~~ to CalOptima Health's Policies and Procedures. Board Members, ~~Employees~~employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available ~~on InfoNet and a separate web portal accessible~~ to Board Members, ~~Employees,~~employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The ~~CalOptima Health~~ Board ~~of Directors~~, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The ~~CalOptima Health~~ Board ~~of Directors~~ delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an ~~Employee~~employee of CalOptima Health, who handles compliance

oversight and activities full-time. The Chief Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the ~~CalOptima Health~~ Board ~~of Directors~~ remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board ~~of Directors~~ on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to ~~specifically~~ escalate issues of concern directly to the Board ~~of Directors~~. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the ~~CalOptima Health~~ Board ~~of Directors~~, CEO, CalOptima Health's ~~Executive Staff~~executive staff and departmental ~~Management~~management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, ~~internal and FDR auditing and monitoring~~Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's ~~Executive Staff to~~executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The ~~CalOptima Health~~ Board ~~of Directors~~ delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the ~~CalOptima Health~~ Board ~~of Directors~~.

Back to Item

Back to Agenda

- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- Review and address reports of ~~Monitoring~~monitoring and ~~Auditing~~auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of ~~employment or~~ hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

~~Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter.~~ Adherence to the Compliance Program requirements, including training requirements, shall be a condition of ~~continued~~ employment and a factor in the annual performance evaluation of each Employee. ~~Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter.~~

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs~~, which may.~~ Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D ~~enrollees, Medicare Part D~~members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

Back to Item

Back to Agenda

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her ~~Designee~~designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Chief Compliance Officer ~~and the~~, CalOptima Health ~~Executive Staff, Management~~executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, ~~Employees~~employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and ~~which~~updates courses ~~are updated~~ regularly to ensure that ~~Employees~~employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of ~~compliance by outlining the~~ regulatory requirements and ~~reinforcing~~reinforcement of company expectations ~~of~~for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and ~~Subcontractors~~subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- ~~Online at~~Website: caloptima.org

- ~~Compliance@caloptima.org~~

Back to Item

Back to Agenda

- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

b. Report Directly to Management and Executive Staff

CalOptima Health ~~Employees~~employees are encouraged to contact their immediate ~~Management~~management or ~~Executive Staff~~executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive ~~Staff~~staff or ~~Management~~management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her ~~Management~~management or ~~Executive Staff~~executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, ~~Employees~~employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's ~~policies~~Policies and ~~procedures~~Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and ~~Members~~members.

CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic ~~Member~~member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

Board Members, ~~Employees~~employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, ~~Employees~~employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA ~~privacy~~Privacy and ~~security~~Security Program and policies, including actions that harm the privacy of ~~Members~~members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ~~Sanctions~~sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, ~~Employees~~employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative ~~Sanctions~~sanctions and/or

Back to Item

Back to Agenda

penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health ~~Employees~~employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and ~~serve~~serves as a guide for which ~~Monitoring~~monitoring and ~~Auditing~~auditing activities ~~to perform~~are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas ~~as well as the operations of FDRs. .~~ ~~Operations and processes will be evaluated based on:~~

Operations and processes will be evaluated based on:

1) Deficiencies found by ~~Regulatory Agencies~~regulatory agencies
2) Deficiencies found by internal and external ~~Audit~~audit and ~~Monitoring~~monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
~~5)~~6) The OIG Work Plan
~~6)~~7) Monitoring dashboard trends

The ~~Chief Compliance Officer~~Director of the Internal Audit Department, or his/her ~~Designee~~designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the ~~Chief Compliance Officer~~Director of the Internal Audit Department , or his/her ~~Designee~~designee, and presented to the Compliance Committee, for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

Back to Item

Back to Agenda

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal ~~and external~~ auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Internal Audit ~~and Oversight (A&O) team~~Department manages a dashboard of key compliance metrics that serves as a ~~Monitoring~~monitoring tool to track ~~compliant~~ performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. ~~A&O also~~The Internal Audit Department performs audits ~~as per~~ based on the AWP. The ~~Monitoring~~monitoring and ~~Auditing~~auditing results are communicated to ~~Executive Management~~executive staff, the Compliance Committee, and the ~~CalOptima Health~~ Board ~~of Directors~~.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee, and the ~~CalOptima Health~~ Board ~~of Directors~~.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual ~~Risk~~ Assessment

The ~~Chief Compliance Officer~~Director, Delegation Oversight, or his/her designee, will conduct an annual comprehensive risk assessment to determine ~~FDRs'~~an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which ~~includes~~include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the Chief Compliance ~~Department for a suggested~~Officer to collaborate in determining appropriate follow-up ~~audit~~. FDRs determined to be high ~~–~~risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the ~~Chief Compliance Officer~~Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

Back to Item

Back to Agenda

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The ~~A&O~~Delegation Oversight ~~team~~ Department manages a dashboard of key compliance metrics that serves as a ~~Monitoring~~monitoring tool to track compliant performance of ~~FDRs~~FDRs' case management, credentialling, claims, and ~~UM. A&O also~~utilization management. Delegation Oversight performs audits as per the FDR AWP. The ~~Monitoring~~monitoring and ~~Auditing~~auditing results are communicated to ~~Executive Management~~executive staff, the Compliance Committee, and the ~~CalOptima Health~~ Board ~~of Directors~~.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, ~~Employees~~employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, ~~Employees~~employees, contractors, Providers, and FDRs are required to disclose their ~~Participation Status~~participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and ~~when Board Members, Employees, Providers and FDRs~~if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

Back to Item

Back to Agenda

The Chief Compliance Officer and/or Director of FWA/Privacy, in conjunction with the Office of Compliance, FWA/Privacy ~~team~~Department and other key staff, are responsible for reviewing cases of non-compliance and ~~suspect~~suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is complete, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive ~~management~~staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through ~~compliance~~Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

1

Back to Item

Back to Agenda

FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer~~,~~ in conjunction with the Director, FWA & Privacy or his/her ~~Designee~~designee, in conjunction with other compliance activities~~, and investigations~~. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her ~~Designee~~designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her ~~Designee~~designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the ~~CalOptima Health~~ Board ~~of Directors~~, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary~~,~~ or corrective~~,~~ action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by ~~the~~ CalOptima Health Programs ~~is~~are appropriately delivered to ~~Members~~members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health 2024 Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

Orange County Health Authority
dba CalOptima Health

2024 Compliance Plan

(Revised September 2023)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Back to Item

Back to Agenda

TABLE OF CONTENTS

Back to Item

Back to Agenda

Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date policies and procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**
2. **Compliance Officer, Compliance Committee, High-Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring. Auditing, and Identification of Compliance Risks**
7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or with the approval of CalOptima Health, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on the CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive

section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who handles compliance oversight and activities full-time. The Chief Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within

CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.

- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately

address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance

Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department , or his/her designee, and presented to the Compliance Committee, for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee, and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director, Delegation Oversight, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management, credentialling, claims, and utilization management. Delegation Oversight performs audits as per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted

Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA/Privacy, in conjunction with the Office of Compliance, FWA/Privacy Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is complete, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA & Privacy or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health 2024 Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

20234 Code of Conduct

(Revised ~~December~~ September ~~2022~~2023)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

TABLE OF CONTENTS

Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions.

This document is a guide with 12 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

Code of Conduct 12 Principles

1. Mission, Vision, and Values:

CalOptima Health is committed to its Mission, Vision, and Values

2. Member Rights:

CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

3. Compliance with the Law:

CalOptima Health is committed to conducting all activities and operations in compliance with applicable law.

4. Business Ethics:

In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

5. Conflicts of Interests:

Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima Health.

6. Compliance Program Reporting:

Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

7. Confidentiality:

Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

8. Public Integrity:

CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.

9. Business Relationships:

Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.

10. Discrimination:

CalOptima Health acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.

11. Participation Status:

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

12. Government Inquiries/Legal Disputes:

Employees shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Code of Conduct Principles and Standards

Principle	Standard
1. Mission, Vision, and Values CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
~~**Compliance with the Law**~~ **2. Member Rights** CalOptima Health is committed to ~~conducting all activities and operations in compliance with applicable law.~~ meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes**

Principle	Standard
	CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws. ~~**Transparent, Legal, and Ethical Business Conduct**~~ ~~CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima Health depends on its Board members, employees, and those who do business with it to help fulfill this commitment.~~ ~~**Obeying the Law**~~ ~~Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health.~~ ~~**Fraud, Waste, & Abuse (FWA)**~~ ~~CalOptima Health shall refrain from conduct, which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.~~ ~~**Political Activities**~~ ~~CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their~~

Principle	Standard
	~~own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities.~~ ~~**Anti-Trust**~~ ~~All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.~~
~~**Member Rights**~~ **3. Compliance with the Law** CalOptima Health is committed to ~~meeting the health care needs of its members by providing access to quality health care services.~~conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima Health depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees,~~**Member Choice, Access to Health Care Services, Continuity of Care Employees**~~ and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees,

Back to Item

Back to Agenda

Principle	Standard
	and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with ~~CalOptima Health policies and procedures and~~ applicable ~~law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for~~antitrust, unfair competition, and similar laws which regulate competition. Such persons ~~with special needs.~~shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings. ~~**Cultural and Linguistic Services**~~ ~~CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education.~~ ~~**Disabled Member Access**~~ ~~CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members.~~ ~~**Emergency Treatment**~~

Principle	Standard
	~~Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards.~~ ~~**Grievance and Appeals Processes**~~ ~~CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.~~
~~2.~~4. **Business Ethics** In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies**

Back to Item

Back to Agenda

Principle	Standard
	CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
5. Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Health Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; (2) be a director, officer, or consultant of any such contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any such contractor or association of contractors.
~~3.~~ **6.** ~~CalOptima Health and its~~ **Compliance Program Reporting** Board members ~~and~~, employees ~~shall~~, and contractors have a duty to comply with ~~laws and regulations governing public agencies.~~ CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's own policies in accordance with CalOptima Health's reporting policies and its Compliance Plan. Such reports may be made to a Supervisor or the Chief Compliance Officer. Reports can also be made to CalOptima Health's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition,

Back to Item

Back to Agenda

Principle	Standard
	failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees. **No-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies. ~~**Public Records**~~ ~~CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies.~~ ~~**Public Funds**~~ ~~CalOptima Health, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel.~~ ~~CalOptima Health, its Board members, and employees shall comply with~~

Principle	Standard
	~~applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations.~~ ~~**Public Meetings**~~ ~~CalOptima Health, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.~~
~~4.~~7. **Confidentiality** Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

Back to Item

Back to Agenda

Principle	Standard
8. Public Integrity CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, and employees shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
~~5.~~**9. Business Relationships** Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima Health, or CalOptima Health members. **Gifts to CalOptima Health** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima Health and its programs unless specifically permitted under CalOptima Health policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and

Back to Item

Back to Agenda

Principle	Standard
	business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima Health** Employees may provide gifts, entertainment, or meals of nominal value to CalOptima Health's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Health policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima Health. **Third-Party Sponsored Events** CalOptima Health's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Health policies on this subject. In no event, shall CalOptima Health participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima Health or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Health policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima Health intends that these standards be construed broadly to avoid even the appearance of improper activity.
~~**Conflicts of Interests**~~ ~~Board members and employees owe a duty of undivided and unqualified~~	~~**Conflict of Interest Code**~~ ~~Designated employees, including Board members, shall comply with the requirements of the CalOptima Health Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of~~

Back to Item

Back to Agenda

Principle	Standard
~~loyalty to CalOptima Health.~~	~~impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations.~~ ~~**Outside Services and Interests**~~ ~~Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.~~
~~6.~~10. **Discrimination** CalOptima Health acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
~~7.~~11. **Participation Status** CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by

Principle	Standard
CalOptima Health's programs.	conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
~~8.~~12. **Government Inquiries/Legal Disputes** Employees shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with

Principle	Standard
	instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
~~**Compliance Program Reporting**~~ ~~Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.~~	~~**Reporting Requirements**~~ ~~All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's own policies in accordance with CalOptima Health's reporting policies and its Compliance Plan. Such reports may be made to a Supervisor or the Chief Compliance Officer. Reports can also be made to CalOptima Health's hotline number below. Persons making reports to the hotline can do so on an anonymous basis.~~ ~~**Compliance and Ethics Hotline: 855-507-1805**~~ ~~**Disciplinary Action**~~ ~~Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs.~~ ~~**Training and Education**~~ ~~CalOptima Health provides training and education to Board members, employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees.~~ ~~**No Retaliation Policy**~~ ~~CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment.~~ ~~**Referrals of FWA to Government Agencies**~~ ~~CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima~~

Principle	Standard
	~~Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies.~~ ~~**Certification**~~ ~~All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.~~

1

2024 Code of Conduct

(Revised September 2023)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

TABLE OF CONTENTS

Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions.

This document is a guide with 12 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

Code of Conduct 12 Principles

1. **Mission, Vision, and Values:**
   CalOptima Health is committed to its Mission, Vision, and Values
2. **Member Rights:**
   CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.
3. **Compliance with the Law:**
   CalOptima Health is committed to conducting all activities and operations in compliance with applicable law.
4. **Business Ethics:**
   In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.
5. **Conflicts of Interests:**
   Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima Health.
6. **Compliance Program Reporting:**
   Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.
7. **Confidentiality:**
   Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.
8. **Public Integrity:**
   CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.
9. **Business Relationships:**
   Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.
10. **Discrimination:**
    CalOptima Health acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.
11. **Participation Status:**
    CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.
12. **Government Inquiries/Legal Disputes:**
    Employees shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Code of Conduct Principles and Standards

Principle	Standard
1. Mission, Vision, and Values CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. Member Rights CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes**

Principle	Standard
	CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law CalOptima Health is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima Health depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members,

Back to Item

Back to Agenda

Principle	Standard
	employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors

Principle	Standard
	shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
5. Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Health Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; (2) be a director, officer, or consultant of any such contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any such contractor or association of contractors.
6. Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's own policies in accordance with CalOptima Health's reporting policies and its Compliance Plan. Such reports may be made to a Supervisor or the Chief Compliance Officer. Reports can also be made to CalOptima Health's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or

Back to Item

Back to Agenda

Principle	Standard
	Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees. **No-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.
7. Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology

Principle	Standard
policies, procedures, and applicable laws.	for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Public Integrity CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, and employees shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

Principle	Standard
9. Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima Health, or CalOptima Health members. **Gifts to CalOptima Health** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima Health and its programs unless specifically permitted under CalOptima Health policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima Health** Employees may provide gifts, entertainment, or meals of nominal value to CalOptima Health's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Health policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima Health. **Third-Party Sponsored Events** CalOptima Health's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Health policies on this subject. In no event, shall CalOptima Health participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima Health or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where

Principle	Standard
	there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Health policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima Health intends that these standards be construed broadly to avoid even the appearance of improper activity.
10. Discrimination CalOptima Health acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
11. Participation Status CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies.

Principle	Standard
	Disclosure of Participation Status Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
12. Government Inquiries/Legal Disputes Employees shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

Orange County Health Authority
dba CalOptima Health

~~2023~~2024 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised ~~December~~ September ~~2022~~2023)

Document maintained by: Fay Ho
CalOptima Health Director FWA and Privacy Officer

TABLE OF CONTENTS

Back to Item

Back to Agenda

I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, ~~CEO~~Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.08
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

Back to Item

Back to Agenda

II. DEFINITIONS

Abuse ("Abuse") means actions that may, directly or indirectly, result in~~:~~ unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. FWA TRAINING

FWA training is provided to all Board Members, contractors, and ~~Employees~~employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. First-tier, downstream and related parties (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, ~~Employees~~employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of ~~Member~~member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health ~~Members~~members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, ~~or enrolling, individuals in the CalOptima Health Programs, etc.);~~etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average ~~Member~~member in terms of cost or quantity, disproportionate utilization of controlled

Back to Item

Back to Agenda

substances, use of prescription medications for excessive periods of time, ~~high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims,~~ misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train ~~Employees~~employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board Members, ~~Employees~~employees, contractors, FDRs, and ~~Members~~members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. ~~-~~Members, FDRs, ~~Employees~~employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. ~~-~~Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ~~Audits~~audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and ~~Monitoring Activities~~monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and ~~Audits~~audits.

Back to Item

Back to Agenda

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the PBM will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends ~~will be~~are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ~~Members~~members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;

- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM ~~will~~ go through the same risk assessment process.~~-~~ The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the ~~Member~~member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ~~Member~~member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a ~~Member~~member the wrong amount.

d. Sample Indicators

No ~~one~~single indicator is evidence of FWA.~~-~~ The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. ~~-~~The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).
- Photocopies of claim forms and bills, or handwritten claims and bills.

Back to Item

Back to Agenda

- Provider's last name is the same as the ~~Member~~member/patient's last name.
- ~~Insured's~~The insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA ~~database~~case management system and a ~~report is~~reports are routinely generated and ~~submitted to~~shared with the Chief Compliance Officer~~,~~ and Compliance Committee.~~ -~~ In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected ~~Members~~members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of ~~Member~~member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;

Back to Item

Back to Agenda

- The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board Members, ~~Employees~~employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. -FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. -Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health ~~Members~~members; and/or
- Schemes with large financial risk to CalOptima Health, or its ~~Members~~members.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. -Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

Back to Item

Back to Agenda

- GA.8022: Performance and Behavior Standards
- ~~GG.1408: Pharmacy Audits and Reviews~~
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- ~~MA.1615: Corrective Action Plan for Practitioners~~
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

Orange County Health Authority
dba CalOptima Health

2024 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2023)

Document maintained by: Fay Ho
CalOptima Health Director FWA and Privacy Officer

TABLE OF CONTENTS

Back to Item

Back to Agenda

I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.08
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

Back to Item

Back to Agenda

II. DEFINITIONS

Abuse ("Abuse") means actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. FWA TRAINING

FWA training is provided to all Board Members, contractors, and employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. First-tier, downstream and related parties (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board Members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health

identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the PBM will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;

- ► Analysis of pharmacy billing and provider prescribing practices;
- ► Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- ► Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- ► Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- ► Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- ► Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- ► Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- ► Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- ► Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- ► Claims that show any altered information (dates, codes, names).
- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the member/patient's last name.
- ► The insured's address is the same as the servicing provider.
- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.

- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or

- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. When the root cause of the potential FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board Members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract

and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- Schemes with large financial risk to CalOptima Health, or its members.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions

Back to Item

Back to Agenda

- HH.2005: Corrective Action Plan
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

CalOptima Health

2024 HIPAA Privacy and Security Program

Protection of Member Health Information

(September 2023)

Back to Item

Back to Agenda

TABLE OF CONTENTS

Back to Item

Back to Agenda

I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

Back to Item

Back to Agenda

III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) and relates to:

1. The past, present, or future physical or mental health or condition of a member;
2. The provision of health care to a member; or
3. Past, present, or future payment for the provision of health care to a member.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);
3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;

Back to Item

Back to Agenda

6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $126 per violation to $1,900,000 per year, in addition to costs

Back to Item

Back to Agenda

and attorneys' fees, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

Protection of CalOptima Health electronic information resources encompasses:

- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
- Protecting other electronic assets and storage media (e.g., USB thumb drives, external hard drives, CD- ROM/DVD disks, floppy disks, magnetic tapes, videotapes, SD

memory cards, etc.) from unauthorized access and theft, to ensure that ePHI contained within is accessed, used, and/or disclosed only by authorized persons.

V. WRITTEN POLICIES AND PROCEDURES FOR HIPAA PRIVACY PROGRAM

CalOptima Health's policies and procedures for the HIPAA Privacy and Security Program are located on CalOptima Health's intranet, InfoNet, which is accessible to all employees. Policies and procedures are available to CalOptima providers and health networks on CalOptima Health's website.

CalOptima Health maintains the written policies and procedures and other records related to implementation for ten years from the date created or the date last in effect, whichever is later.

VI. PRIVACY OFFICER, CHIEF INFORMATION SECURITY OFFICER AND COMPLIANCE COMMITTEE

The Privacy Officer and Chief Information Security Officer (CISO) shall work with the Compliance Committee to assist in the implementation of the HIPAA Privacy and Security Program. The Compliance Committee is chaired by the Chief Compliance Officer (CCO), and the members of the Compliance Committee are comprised of key stake holders in the HIPAA Privacy and Security Program, including the Privacy Officer, the CISO, Legal Counsel, Chief Executive Officer (CEO), and Chief Operations Officer (COO). This Committee is responsible for overseeing the following activities:

- Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy policies and procedures as part of daily operations;
- Determining the appropriate strategy/approach to promote compliance with the Privacy Program and Security Program and detection of any potential violations, such as through hotlines and other reporting mechanisms;
- Developing a system to solicit, evaluate and respond to referrals for privacy investigations, security incidents and breaches;
- Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;
- Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, security incident reports, referrals for privacy investigations, etc.;
- Analyzing and data collecting of business processes, systems and relationships to understand the cause of a reportable security incident/HIPAA breach;
- Developing policies to better prevent or address reportable security incidents/HIPAA breaches; and

Back to Item

Back to Agenda

- Developing resolutions which stem from reportable security incidents/HIPAA breaches.

When a potential problem is identified, the Privacy Officer and the CISO may convene a designated group of individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

VII. GENERAL PROVISIONS ON SAFEGUARDS AND MITIGATION PROCEDURES

Security Safeguards

CalOptima Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in all forms including electronic and hard copy. CalOptima Health employees are trained and educated on the HIPAA Security regulations to ensure that reasonable measures are taken to safeguard PHI from any use or disclosure that would violate the HIPAA regulations or CalOptima's privacy policies. CalOptima Health employees have limited access to PHI through job-based access and password protection. CalOptima Health also has security tools in place to protect information from those who do not need to access PHI to perform their job functions. CalOptima Health's established physical safeguards include electronic building access, restricted area access, limited access to mailroom processing, clean desk policy and controlled system access to PHI for employees and contracted personnel to perform their job function.

CalOptima Health has processes to limit employee access to member PHI based on the employee's role and job description. Employees have an obligation to limit the use of PHI to the minimum necessary for their business purposes. CalOptima Health prohibits the use of employee-owned equipment within CalOptima Health's network and employees may not transfer PHI to any portable devices for storage or otherwise without the express permission of CalOptima Health's ITS Department, which if granted, will be processed in accordance with ITS policies and procedures. CalOptima Health data including member PHI may only be used in connection with business purposes.

E-mail Safeguards

E-mail communications between CalOptima Health and an external entity via the internet shall not contain member identifiable PHI unless the e-mail has been encrypted to safeguard the contents from being read by anyone other than the intended receiver. E-mail that is sent within CalOptima Health may contain member identifiable PHI but must be limited to the minimum necessary data required to complete the message.

Mass Disclosure Safeguards

Back to Item

Back to Agenda

Any large mailings that include PHI must be carefully reviewed to ensure that PHI is not inadvertently revealed to an unintended recipient. For example, this might include targeted mailings to members with specific health conditions or disease states (e.g., mailings to members with HIV). Electronic and non-electronic data must be appropriately safeguarded to ensure that PHI is protected, pursuant to CalOptima Health policies and procedures.

VIII. EDUCATION AND TRAINING PROGRAMS

CalOptima Health conducts regular training sessions on the HIPAA regulations, the CalOptima Health Privacy Program, the CalOptima Health ITS Cybersecurity awareness program, and the policies and procedures. All new employees are provided with training within a reasonable period at the New Employee Orientation. All CalOptima Health employees are also required to complete an annual mandatory online Compliance training, which includes a module on HIPAA privacy and security compliance. CalOptima Health shall maintain an annual log of training completion dates and assessment scores for all employees. Focused training will be provided as needed. Failure to complete the mandatory training within the specified timeframe may lead to disciplinary action up to and including termination of the employee.

CalOptima Health will periodically update the policies and procedures to reflect changes in operations or changes to applicable statutes and regulations. CalOptima Health will distribute the updates to affected employees and will provide additional training as necessary to ensure that employees and/or contracted personnel understand the revised policies and procedures.

IX. EFFECTIVE LINES OF COMMUNICATION

Member Complaint Procedure

CalOptima Health has in place procedures for handling complaints from its members regarding implementation of and compliance with the HIPAA privacy regulations as well as State and Federal privacy laws. CalOptima Health's Notice of Privacy Practices directs members with complaints to contact CalOptima Health, the DHCS Privacy Officer, the Secretary of the Health and Human Services or the Office for Civil Rights. Upon receipt of a complaint, the Customer Service Department will provide a copy of each complaint to CalOptima Health's Privacy Officer and forward the complaint to the Grievance and Appeals Resolution Services Department (GARS). GARS will follow the same procedure as when handling other complaints submitted by CalOptima Health members. All responses and other documentation relating to a privacy complaint are maintained in the member's file and by the Privacy Officer for ten years from the date of the last communication on the complaint.

Back to Item

Back to Agenda

Access to Privacy Officer

The Privacy Officer maintains an open door policy for all employees and accepts e-mails, telephone messages or written memoranda regarding any privacy matter. Any individual who has a question or wants to report a potential privacy incident may bring such issues directly to the Privacy Officer, CCO, or CISO. Reports of potential privacy incidents may be made on an anonymous or identifiable basis directly to the Privacy Officer or through the Compliance Hotline at 1-855-507-1805.

Responsibility to Report

CalOptima Health is committed to compliance with the HIPAA and state privacy laws and to correcting violations wherever they may occur in the organization. Every employee is responsible for reporting any activity they suspect violates applicable privacy and security laws, rules, regulations or the HIPAA Privacy and Security Program. CalOptima Health must notify the Department of Health Care Services (DHCS) of any suspected or actual security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

C/O: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019 or FAX (415) 437-8329 or (800) 537-7697 TDD
Email: OCRComplaint@hhs.gov

Back to Item

Back to Agenda

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer, or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with Human Resource policy GA.8022 Progressive Discipline, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

Back to Item

Back to Agenda

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

Back to Item

Back to Agenda

Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
GA.7508p: CalOptima Health Policy and Procedure Review Process *Regulatory Affairs & Compliance, Policies and Procedures*	**A - NEW:** This new policy was created in alignment with the 2024 Department of Health Care Services (DHCS) Contract and outlines CalOptima Health's Policy and Procedure Review Process to develop, review, revise, and retire, and ensure Policies and Procedures comply with regulatory and contractual requirements in alignment with CalOptima Health's mission, and vision. **Program(s):** Administrative Department Point(s) of Contact: Tracy Weske; John Tanner	
HH.3023p: Information Sharing *Privacy*	**A - NEW:** This new policy was created in alignment with the interoperability and data sharing requirements as stated in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide, the CalAIM Enhanced Care Management Policy Guide, CalAIM Data Sharing Authorization Guidance, CalAIM D-SNP Policy Guide and CalAIM Population Health Management Policy Guide to establish CalOptima Health's process to share information with participating First Tier, Downstream, and Related Entities (FDRs), local health jurisdictions, and county and/or other public agencies for purposes of coordinating Medicare and Medi-Cal Covered Services between settings of care. **Program(s):** Medi-Cal; OneCare Department Point(s) of Contact: Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2005: Corrective Action Plan *Office of Compliance*	**B – REVISED:** This policy was updated to reflect timeframes established internally to allow for five (5) days from the formal Immediate Corrective Action Plan (ICAP) request to an internal department or First Tier, Downstream, or Related Entity (FDR) to provide a written plan to address or remediate the deficiency. establish milestones and benchmarks. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annabel Vaughn; Annie Phillips; John Tanner	
HH.2014: Compliance Program *Office of Compliance*	**B – REVISED:** This policy was updated to reflect the inclusion of the Anti-Fraud, Waste and Abuse Plan, and the HIPAA Privacy and Security Program as applicable documents included in the Compliance Program. The attachments section was updated to move publicly available documents to the reference section for version accuracy. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Annabel Vaughn; Annie Phillips; John Tanner	
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI *Privacy*	**B – REVISED:** This policy was updated to reflect a 24 hour deadline for reporting or notification of known or suspected Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI from time of discovery to and from CalOptima Health. The change in mode of reporting privacy breaches and incidents to DHCS via the DHCS Privacy Incident Reporting Portal was also added. Reporting to the CMS IT Service Desk within one (1) hour of initial discovery and associated internal steps and subsequent process for resolution update was added. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.4002: CalOptima Health Internal Oversight *Internal Audit*	**B – REVISED:** This policy was revised to reflect the restructuring of the Audit and Oversight Department to the Internal Audit Department, managing CalOptima Health Internal Operations and the Delegation Oversight Department's focus on routine monitoring and auditing of FDRs. Clarity was added regarding timing for risk assessments to be performed monthly/quarterly and at least annually as determined in the Annual Internal Audit and Monitoring Work Plan. Additional elements to functional areas to be monitored were updated to include those identified as having a potential high or medium risk through the Annual Risk Assessment. **Program(s):** Administrative Department Point(s) of Contact: Kevin Larson; John Tanner	
HH.4003: Annual Risk Assessment *Internal Audit*	**B – REVISED:** This policy was revised to reflect the restructuring of the Audit and Oversight Department to the Internal Audit Department, managing CalOptima Health Internal Operations and the Delegation Oversight Department's focus on routine monitoring and auditing of FDRs. **Program(s):** Administrative Department Point(s) of Contact: Kevin Larson; John Tanner	
HH.2029: Annual Compliance Program Effectiveness Audit *Regulatory Affairs & Compliance*	**C – RETIREMENT:** This policy was reviewed for retirement as there is not a requirement for a policy specific to the Compliance Program Effectiveness (CPE) audit. CalOptima will continue to perform this audit on an annual basis in accordance with Chapter 21, Medicare Managed Care Manual Chapter 21, 50.6.5. **Program(s):** OneCare Department Point(s) of Contact: Annie Phillips; John Tanner	

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive revisions for the CalOptima Office of Compliance, by department.

POLICY	DEPARTMENT
HH.1105: Fraud, Waste, and Abuse Detection	*Fraud, Waste, and Abuse*
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, and Abuse*
HH.5004: False Claims Act Education	*Fraud, Waste, and Abuse*
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	*Privacy*
HH.3003: Verification of Identity for Disclosure of Protected Health Information	*Privacy*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3008: Member Right to Request Confidential Communications	*Privacy*
HH.3009: Access by Member's Authorized Representative	*Privacy*
HH.3010: Protected Health Information (PHI) Disclosures Required by Law	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*
HH.3014: Use of Electronic Mail with Protected Health Information (PHI)	*Privacy*
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3022: Business Associates Agreements	*Privacy*

POLICY	DEPARTMENT
AA.1270: Certification of Document and Data Submissions	*Regulatory Affairs & Compliance*
AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process	*Regulatory Affairs & Compliance*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7505: Regulatory Liaison Responsibilities	*Regulatory Affairs & Compliance*
HH.2002: Sanctions	*Regulatory Affairs & Compliance*
HH.2007: Compliance Committee	*Regulatory Affairs & Compliance*
HH.2014: Compliance Program	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2020: Conducting Compliance Investigations	*Regulatory Affairs & Compliance*
HH.2022: Record Retention and Access	*Regulatory Affairs & Compliance*
HH.2023: Compliance Training	*Regulatory Affairs & Compliance*
HH.2028: Code of Conduct	*Regulatory Affairs & Compliance*
MA.9124: CMS Self-Disclosure	*Regulatory Affairs & Compliance*

Policy:	GA.7508p
Title:	**CalOptima Health Policy and Procedure Review Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance, Policies and Procedures
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This Policy outlines CalOptima Health's Policy and Procedure Review Process to develop, review, revise, retire, and ensure Policies and Procedures comply with regulatory and contractual requirements in alignment with CalOptima Health's mission, and vision.

II. POLICY

A. CalOptima Health shall develop Policies and Procedures (Policies) in alignment with regulatory and contractual requirements that encompass the primary directives and general procedures of the agency while providing guidance in conducting business and accomplishing the mission, and vision of CalOptima Health.

1. All Policies shall be reviewed at least annually and in accordance with the guidelines outlined in this Policy to incorporate changes in applicable laws, regulations and requirements and/or organizational operational changes.

2. All Policies will be reviewed by the Chief Executive Officer (CEO) and Policies with substantive edits not driven by regulatory, legal, or contractual requirements, shall be subject to the CalOptima Health Board of Directors (Board) review and approval, in accordance with CalOptima Health Policy GA.3202: Signature Authority.

3. Updates to existing Policies, including the creation of new Policies, must be communicated to the Health Networks, First Tier, Downstream, and Related Entities (FDRs), vendors, any other delegated entities, and to compliance for the fulfillment of any requirements on a monthly basis.

B. CalOptima Health's Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team manages the Policy review process, to support CalOptima Health's department responsibilities to develop, draft, review, revise, or retire Policies. RAC P&P shall ensure appropriate distribution of Policies reflective of CalOptima Health Health's operations, mission, and vision.

Back to Item

Back to Agenda

C. CalOptima Health Policies shall inform CalOptima Health's staff, Board, Health Networks, FDRs, applicable vendors, other delegated entities and Members of the scope and parameters of CalOptima Health's programs and/or operations.

1. CalOptima Health program-specific Policies shall be utilized by a Health Network or FDR, in accordance with the provisions of their respective contract.

2. CalOptima Health administrative Policies shall provide guidelines to CalOptima Health staff for conducting business operations in support of CalOptima Health's mission, and vision. CalOptima Health employees shall be responsible for reviewing and following all Policies, and any updates thereto.

D. All new and/or revised Policies shall be reviewed and approved by the department's leadership, the Policy Review Committee (PRC) presented to the Board (if applicable) and signed by the Chief Executive Officer (CEO), or their Designee, when applicable.

E. CalOptima Health's Human Resources (HR) Department shall provide all employees, members of the Board, and FDRs or other vendors with instructions on how to access CalOptima Health Policies upon hire or engagement.

F. The RAC P&P team shall make available all approved member-facing CalOptima Health Policies on CalOptima Health's public website, www.caloptima.org, and CalOptima Health internal administrative Policies to the CalOptima Health InfoNet.

G. The RAC P&P team shall maintain all historical versions of Policies (retired and revised) in CalOptima Health's archival system.

H. All CalOptima Health departments shall be responsible for the content and accuracy of their Policies and corresponding Policy attachments.

1. Prior to submission to RAC P&P, all Policy Owners shall ensure CalOptima Health created Member-facing documents have been thoroughly reviewed and processed through the Member Materials Approval (MMA) process.

2. Once Policies and Policy attachments are updated, Policy Owners must ensure any updated versions of their documents cascade across all platforms (e.g., CalOptima Health website, Guiding Care, InfoNet, as applicable).

I. RAC P&P, Policy & Procedure Review Process training shall be available for all CalOptima Health employees, upon request.

III. PROCEDURE

A. Policy Owner Review

1. Current Policy Review/Revision

a. CalOptima Health departments shall review all Policies on an annual basis with the exception of the Human Resources department which reviews Policies on a bi-annual basis.

b. Policy Owners may access, review, and revise their Policy(s) at any time in response to operational changes, regulatory guidance, or contract amendments.

2. New Policy Development

   a. A new Policy may be developed in response to a need for clarity and consistency on an issue, to address audit findings, new laws/regulations/guidance and/or to direct CalOptima Health employees, FDRs, and other contractors on matters including, but not limited to, health and safety, human resources, information services, communications, subpoenas, regulatory requirements, or compliance with CalOptima Health operations.

   b. The universal Policy template found on CalOptima Health's RAC P&P InfoNet page, shall be utilized in the creation of Policies to ensure consistent Policy format.

3. Policy Transfer or Retirement:

   a. A Policy may be transferred to another department or retired for various reasons, including but not limited to, operational changes, changes in the law, or the consolidation/merging of Policies and/or department responsibilities.

   b. The Policy Owner shall also solicit input from potentially affected departments if the Policy will be transferring or retiring the Policy may have unintended consequences or is appropriate based on the circumstances.

      i. If a Policy Owner identifies a need to transfer a Policy, the Policy Owner shall;

         a) Submit a completed Policy Intake Form (PIF), along with the Policy and any applicable attachments.

         a) The Policy Owner shall consult with the receiving department for agreement to the transfer indicating the transfer on the PIF.

      ii. If a Policy Owner identifies a need to retire a Policy, the Policy Owner shall;

         a) Ensure any content that is required as a result of Board's action, contractual requirements, applicable laws, and/or state and federal regulations is addressed or included in another Policy;

         b) Draft a separate desktop procedure (if applicable); and

         c) Complete a Retirement Crosswalk form detailing each section of the Policy is either present in another Policy or is no longer applicable to CalOptima Health and why.

4. All Policy reviews shall comply with the RAC P&P Policy Owner Manual, and shall include an assessment for:

   a. Alignment with the most current and applicable statutory or regulatory guidance, Board action or contractual requirements, including, but not limited to:

      i. DHCS Contract(s);

      ii. CMS Contract(s);

      iii. PACE Contract(s);

      iv. All Plan Letters (APL), Dual Plan Letters (DPL), and Policy Letters (PL);

v. Health Plan Management System (HPMS) Memorandums;

vi. Other sub-regulatory guidance; and

vii. Relevant federal and state laws, regulations, and guidance.

b. Current overlapping Policies and consider whether incorporation or consolidation into one (1) Policy is appropriate.

c. Accuracy of Policy attachments confirming consistency with any proposed changes to the Policy.

d. Input from additional departments or teams impacted by any revisions to the Policy content.

5. Submission of a Policy to the RAC P&P team via email shall include:

a. Draft Policy;

b. Reviewed attachments, if applicable;

c. A completed PIF; and

d. Any documentation supporting edits or Policy creation.

B. Regulatory Affairs & Compliance Policy Review

1. Upon receipt of a complete submission, with all supporting documentation, the RAC P&P team shall:

a. Review the Policy(s) for the following:

i. Adherence to statutory, contractual, and regulatory requirements;

ii. Consistency with other related Policies, if any;

iii. Clarity of necessary provisions (e.g., new regulatory guidance, audit remediation(s));

iv. Accuracy and completeness of references;

v. Accuracy and completeness of attachments, if any; and

vi. Appropriate language, style, and grammar usage.

b. Where appropriate, secure review from legal counsel for specific legal guidance by submitting a request for legal review on behalf of the Policy Owner and manage the resulting legal review outcome.

C. Legal Counsel Policy Review

1. CalOptima Health's designated legal counsel conducts Policy reviews in response to a request for legal review submitted by the RAC P&P team, on behalf of a Policy Owner, as appropriate or as requested by the Policy Owner.

2. The RAC P&P team shall be responsible for coordination of a request for legal review requests (i.e., submissions, responses to Policy Owners, and documentation of reviews). However, Policy Owners are still responsible for ensuring all legal counsel recommended edits are addressed and incorporated into their Policy(s), as applicable.

3. All Policies that require approval by the Board must be reviewed and approved by legal counsel in advance of the requested Board meeting materials submission deadline, as established by the Clerk of the Board.

D. Policy Review Committee (PRC)

1. The PRC is a standing committee responsible for reviewing all CalOptima Health Policies, and corresponding supporting materials, and authorized to create, revise, or retire Policies.

   a. The PRC specifically reviews Policies for operational integrity to ensure their successful implementation and alignment with regulatory requirements and CalOptima Health's mission and vision.

2. The PRC is composed of CalOptima Health's senior management and operational staff or their delegate, as designated by the CEO and Chief Compliance Officer. PRC membership includes:

   a. Chief Compliance Officer

   b. Chief Financial Officer

   c. Chief Information Officer

   d. Chief Medical Officer

   e. Chief Operating Officer

3. Each Policy shall be reviewed and approved by, at minimum, a quorum of the PRC, or more than fifty percent (50%) of the PRC members, or their delegate.

4. All CalOptima Health PRC event Policies will be distributed to the PRC via email, allowing members up to five (5) business days to assess and submit an electronic vote.

5. The RAC P&P team shall:

   a. Develop and maintain the schedule, deadlines, and agenda(s) of the PRC;

   b. Facilitate the PRC meetings;

   c. Ensure documentation of PRC members' approval; and

   d. Coordinate final edits with Policy Owners upon approval from the PRC.

6. The Policy Owner, or their delegate, shall:

   a. Submit all Policy materials (e.g., revised Policy, PIF, updated attachments, etc.) no later than four (4) weeks prior to the preferred PRC meeting date (unless otherwise indicated by the RAC P&P team);

i. If updates to the Policy necessitate Board approval, all Policy materials shall be submitted no later than two (2) months prior to the Board meeting date to ensure appropriate scheduling of a PRC meeting.

b. The Policy Owner listed as the contact listed on the PIF is required to reply for the Policy if questions should arise during the PRC review; and

c. Consider revisions to the Policy(s) as appropriate, upon recommendation from the PRC.

E. CalOptima Health Board of Directors (Board) Policy Review

1. Although the Board and the Compliance Committee have authorized the CEO and the PRC, to create, review, revise, and retire CalOptima Health's Policies, all new Policies, substantive edits to Human Resources Policies, and substantive edits to Policies not required to comply with existing law must obtain Board approval after PRC and prior to CEO review.

2. For Policies that do not require approval by the Board, upon request, CalOptima Health shall provide Policy updates to the Board.

F. Regulatory Agency Review

1. If approval by a Regulatory Agency is required, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), or the Department of Managed Health Care (DMHC), CalPERS, or any other outside entity, the RAC P&P team shall coordinate with the appropriate CalOptima Health teams to submit the Policy(s) to the appropriate Regulatory Agency for approval, if applicable, and in accordance with CalOptima Health's contracts with its regulators.

a. Per DHCS guidance and in accordance with CalOptima Health Policy AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process, Policies submitted to DHCS shall be submitted as File and Use if they are unrelated to APLs, implementation readiness, or other DHCS deliverables.

2. For policies submitted to DHCS, if written Regulatory Agency approval is not received within sixty (60) calendar days of submission of the Policy(s), the RAC P&P team shall notify DHCS that the sixty (60) calendar day deadline has passed and that CalOptima Health elects to move forward with the Policy per the CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal. The Policy shall then move forward in the process.

a. If a Regulatory Agency subsequently requests revisions to a Policy approved by PRC, the RAC P&P team, in collaboration with the Policy Owner, shall incorporate any modifications requested by the Regulatory Agency within the required time frame.

3. If state and/or federal mandate(s) requires implementation of a Policy prior to regulatory approval, CalOptima Health shall move forward with implementation of the Policy to ensure regulatory deadlines are met and shall incorporate any modifications to the Policy subsequently received from the Regulatory Agency.

4. Any exceptions to the Regulatory Agency approval process shall require approval by the CEO, or Designee, with concurrence from legal counsel, as appropriate.

G. Chief Executive Officer (CEO) Approval

1. Within seven (7) business days of obtaining all required approvals (e.g., CalOptima Health legal review, PRC, Board, Regulatory Agencies, etc.), the RAC P&P team shall submit the Policy(s) to the CEO for final review, approval, and signature completing the review cycle.

H. Posting of Updated Policies and Procedures (Policies)

1. Upon CEO approval of Policies, the RAC P&P team shall publish approved Policies in Compliance 360 (C360) database. Public website approved Member-facing Policies shall be viewable on CalOptima Health's website at www.CalOptima.org, and internal only and all other approved Policies shall be viewable to CalOptima Health employees on the CalOptima Health InfoNet within seven (7) business days.

2. The RAC P&P team shall update shared Policy Owner folders on the InfoNet RAC P&P page within seven (7) business days following publication in C360. The folder content will contain the recent CEO approved Policy (PDF format), the Word (locked for tracking) Policy release, and attachments as applicable.

3. The RAC P&P team shall also update the Policy "Table of Contents" accessible on the InfoNet RAC P&P page to ensure all Policy resources are accurate.

I. Monthly Distribution of Policy and Procedure Updates

1. The RAC P&P team shall provide two (2) Monthly Policy Snapshot email notifications of Policies approved in the prior month by the tenth (10^{th}) business day of the current month to:

a. CalOptima Health employees; and

b. Health Networks, FDRs, or any impacted vendors or delegates, disseminated through internal processes by applicable CalOptima Health departments.

IV. ATTACHMENT(S)

A. Charter of the CalOptima Health Policy Review Committee (PRC)

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Policy AA.1275: Department of Health Care Services (DHCS) File & Use Submission Process
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
G. CalOptima Health Policy Review Committee (PRC) Charter
H. Medicare Managed Care Manual, Chapter 21: Compliance Program Guidelines
I. CalOptima Health Policy Intake Form (PIF)
J. Prescription Drug Benefit Manual, Chapter 9: Compliance Program Guidelines
K. Regulatory Affairs & Compliance, Policies and Procedures, Policy Owner Manual

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GA.7508	CalOptima Health Policy and Procedure Review Process	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Board of Directors (Board)	The Board of Directors of CalOptima Health, which serves as the Governing Body of CalOptima Health, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 et seq.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
FDR	First Tier, Downstream, or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Health Network (HN)	The contracted health networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary who is enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Policy	A formal document that communicates broad principles of operation and standards on a particular subject to guide the actions and decision-making of individuals. Desktop Policies and procedures are not included.
Policy Owner	Each CalOptima Health department designated staff member with the lead responsibility of the department's Policy and procedure oversight.
Policy Review Committee (PRC)	A committee, chaired by the Chief Compliance Officer's designated CalOptima Health staff member, with the responsibility to oversee the review and implementation of CalOptima Health Policies and procedures and ensure compliance with regulatory guidance and existing operational procedures. The committee is comprised of senior management and key operational staff that have subject matter expertise and knowledge of regulations and standards.
Procedure	An operational set of specific action steps and processes required to support the implementation of the Policy where needed, that may identify roles and assign responsibilities for the activities.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes covered services.

Term	Definition
Regulatory Agencies	For the purposes of this Policy, regulatory agencies include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.

1

CHARTER OF THE CALOPTIMA HEALTH POLICY REVIEW COMMITTEE (PRC)

Purpose

The Policy Review Committee ("PRC") was established through adoption of the Orange County Health Authority ("CalOptima Health") Compliance Plan. The purpose of the PRC is to:

1. Oversee the review and implementation of policies and procedures designed to mitigate and respond to various compliance and regulatory risks facing CalOptima Health; and

2. Assist the Chief Compliance Officer (CCO), Chief Executive Officer (CEO), and the CalOptima Health Board of Directors in fulfilling their respective oversight responsibility of the regulatory and operational requirements to which CalOptima Health must adhere.

Composition

The PRC is composed of CalOptima Health's senior management and operational staff, as designated by the CEO and CCO. Committee membership consists of individuals that have subject matter expertise and operational knowledge of the regulations and standards related to operational areas and may include Chief-level staff, as well as executive and non-executive directors, including those serving in an interim capacity.

The size of the PRC shall be commensurate to the different functional areas within CalOptima Health in order to provide a representational audience and ensure accuracy for policies that impact multiple CalOptima Health departments.

PRC members will include the following individuals or their designated delegates:

- Chief Compliance Officer
- Chief Financial Officer
- Chief Information Officer
- Chief Medical Officer
- Chief Operating Officer

Each PRC voting member shall have a delegate. A delegate must be a member of their staff entrusted to make decisions regarding policies and procedures and vote on their behalf. When feasible, a delegate must be Director-level, or above. Under certain circumstances, PRC members and their delegates may be changed in response to staffing changes; this may, or may not, lead to a Director holding an interim voting member position usually allotted to an Executive Director, or Chief. All changes must be requested by the impacted Chief and approved by the PRC Chair.

The CCO shall designate the PRC chairperson. Under the circumstances that it is not feasible for the CCO to designate the PRC chairperson, the members of the PRC may elect a chairperson by majority vote.

CHARTER OF THE CALOPTIMA HEALTH POLICY REVIEW COMMITTEE (PRC)

Responsibilities

Overall, the PRC is responsible for reviewing all policies and procedures, and corresponding supporting materials, and is authorized to create, revise, or retire policies and procedures.

The CEO and the Compliance Committee jointly delegate the following responsibilities to PRC:

- Recommend policies and strategies that maintain and improve CalOptima Health's mission to serve member health with excellence and dignity, respecting the value and needs of each person.
- Draft, review, approve, and/or update policies and procedures to ensure the successful implementation consistent with regulatory, legal, and contractual requirements.
- Suggest and implement systems, controls, and other actions, as appropriate, and necessary, to ensure that CalOptima Health and its FDRs conduct activities and operations in compliance with applicable laws, regulations, and sound business ethics.

Limitation of Authority

Although the CalOptima Health Board of Directors and Compliance Committee have authorized the CEO and the PRC, to create, review, revise, and retire CalOptima Health's policies and procedures, all new policies, substantive edits to Human Resources policies, and substantive edits to policies not required to comply with existing law, in accordance with CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, must obtain CalOptima Health Board of Directors approval after PRC and prior to CEO review.

Meetings

The PRC is a standing committee required to convene, on a monthly basis at a minimum, and as approved by the PRC Chair. Meetings are held virtually with all appropriate supporting documents distributed to PRC members for review and vote.

During any PRC meeting, a quorum shall be established when one (1) more than half of the members of the PRC are represented. Each PRC member shall cast one (1) vote for each item presented to the PRC for approval.

Action of the PRC shall be based on the affirmative vote of a majority of the PRC quorum.

Regulatory Affairs and Compliance is responsible for facilitating meetings, executing approved policies, and maintaining all documentation for PRC meetings.

Reporting

On a monthly basis, CalOptima Health's employees, FDRs, and suppliers receive a comprehensive memorandum containing all policies and procedures approved during the prior month. Such memorandum details the following:

- Policy number and title
- Policy action
- Policy line of business
- Links to approved policies

On an annual basis, the PRC will receive and review the *End-of-Year P&P Report* demonstrating progress made for all CalOptima Health policies and procedures.

Custodian: Manager, Regulatory Affairs & Compliance (Policies & Procedures)

Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima Health's Office of Compliance.

CalOptima Health's Office of Compliance recognizes that issues of non-compliant performance may be identified by internal departments and FDRs that are outside of the Auditing, and operational Monitoring and investigations conducted by the Office of Compliance. This policy does not restrict the internal departments and ~~its~~ FDRs from performing their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners.

II. POLICY

A. CalOptima Health's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima Health departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs.

B. CalOptima Health's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima Health's Office of Compliance shall require CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements, which CalOptima Health or its regulators have identified as non-compliant, within time frames established by CalOptima Health's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

   a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima Health's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima Health's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP request, as determined by CalOptima Health's Office of Compliance, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency. ~~is required to cease non-compliant activities within two (2) business days of receiving the ICAP request~~.

   b. The internal department or FDR shall provide a written response within ~~three (3)~~five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima Health's Chief Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's ~~Compliance Officer~~Chief Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's ~~Compliance Officer~~Chief Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Delegation Oversight Committee (DOC)~~Audit & Oversight Committee (AOC)~~ and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

   a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's ~~Compliance Officer~~Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima Health's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's ~~Compliance Officer~~Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima Health's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health's Office of Compliance.

3. CalOptima Health's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the ~~Compliance Officer~~Chief Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the ~~AOC~~ DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the ~~Compliance Officer~~Chief Compliance Officer for review and sign off.

   b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the ~~Compliance Officer~~Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in

accordance with CalOptima Health Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

c. CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the ~~AOC~~ DOC and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
F. CalOptima Health Policy HH.2002: Sanctions
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	12/01/2016	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
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Revised	05/05/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
~~Audit & Oversight Committee (AOC)~~	~~A subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima Health's delegated functions. The composition of the AOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001Δ: Audit & Oversight Committee.~~
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Term	Definition
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima Health's Office of Compliance.

CalOptima Health's Office of Compliance recognizes that issues of non-compliant performance may be identified by internal departments and FDRs that are outside of the Auditing, and operational Monitoring and investigations conducted by the Office of Compliance. This policy does not restrict the internal departments and FDRs from performing their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners.

II. POLICY

A. CalOptima Health's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima Health departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs.

B. CalOptima Health's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima Health's Office of Compliance shall require CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements, which CalOptima Health or its regulators have identified as non-compliant, within time frames established by CalOptima Health's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

   a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima Health's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima Health's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP request, as determined by CalOptima Health's Office of Compliance, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency.

   b. The internal department or FDR shall provide a written response within five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima Health's Chief Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Delegation Oversight Committee (DOC) and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

   a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima Health's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima Health's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health's Office of Compliance.

3. CalOptima Health's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Chief Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the Chief Compliance Officer for review and sign off.

   b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Health Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

c. CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
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Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Health Program.

Term	Definition
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
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Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima Health or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima Health**	
Date of Incident		**Date CAP Due to CalOptima Health**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			
		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

CalOptima Health

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
2	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			
		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non-compliance.

Generated by: (Responsible Party)	Name, Title	Signature	Date
Approved by: (CalOptima Health Office of Compliance)	Name, Title	Signature	Date

Policy:	HH.2014
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2008
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ ~~☐~~ Administrative

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima Health policies.

II. POLICY

A. CalOptima Health shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima Health's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this Policy.

C. CalOptima Health shall revise and update the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, as changes occur in CalOptima Health's needs, regulatory requirements, and applicable laws.

D. The CalOptima Health Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program~~,~~ and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Health Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

Back to Item

Back to Agenda

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program and/or related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima Health operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan, ~~and~~ Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan, ~~and/or~~ Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, ~~to the Compliance Plan~~ may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation
~~B. CalOptima Health Compliance Plan~~

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Anti-Fraud, Waste and Abuse Plan
~~B.~~D. CalOptima Health HIPAA Privacy and Security Program
~~C.~~E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~D.~~F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~E.~~G. CalOptima Health PACE Program Agreement
~~F.~~H. Medicare Managed Care Manual, Chapter 21
~~G.~~I. Medicare Prescription Drug Benefit Manual, Chapter 9
~~H.~~J. Office of Inspector General Guidelines for Operating an Effective Compliance Program
~~I.~~K. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
~~J.~~L. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting

12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	12/01/2016	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2014	Compliance Program	Medi-Cal OneCare PACE

Back to Item

Back to Agenda

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Chief Human Resources Officer.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima Health as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima Health.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.

Policy:	HH.2014
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2008
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

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B. CalOptima Health's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this Policy.

C. CalOptima Health shall revise and update the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, as changes occur in CalOptima Health's needs, regulatory requirements, and applicable laws.

D. The CalOptima Health Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Health Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

III. PROCEDURE

Back to Item

Back to Agenda

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program and/or related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima Health operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Anti-Fraud, Waste and Abuse Plan
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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
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Date	Meeting
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	12/01/2016	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2014	Compliance Program	Medi-Cal OneCare PACE

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Term	Definition
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Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
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Governing Body	The Board of Directors of CalOptima Health.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.

Back to Item

Back to Agenda

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima Health's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima Health, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director, 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for existing FDRs, or sixty (60) calendar days for new FDRs of this notice.

Which CalOptima Health program(s) does this form pertain to? Select all that apply:	☐ Medi-Cal ☐ PACE ☐ OneCare

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima Health programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module.* (The Organization shall maintain records as evidence of completed training)

☐ An internal training program that utilizes content available in CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima Health's Office of Compliance for review to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) calendar days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

III. **Compliance Plan and Code of Conduct Requirements**. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima Health's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima Health's Office of Compliance for review to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the Medi-Cal Suspended and Ineligible Provider List (S & I Medi-Cal), Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals & Entities list, System for Award Management (SAM)/General Services Administration (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), Restricted Provider Database (RPD) (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima Health within five (5) calendar days, the relationship with the listed person/entity may be terminated as it relates to CalOptima Health, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima Health policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima Health, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima Health policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e., sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima Health upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

CalOptima Health

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima Health prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima Health program(s) does this form pertain to? Select all that apply.	☐Medi-Cal ☐PACE ☐OneCare

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below.

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below.

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima Health.	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor:	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with CalOptima Health's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima Health or CMS upon request.	☐Yes ☐No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima Health's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima Health's Code of Conduct, CalOptima Health's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Back to Item

Back to Agenda

Policy:	HH.2029
Title:	**Annual Compliance Program Effectiveness Audit**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	12/31/2022
Retirement Date:	09/01/2023
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health's Office of Compliance determines the overall effectiveness of the Compliance Program.

II. POLICY

A. CalOptima Health will assess the overall effectiveness of its Compliance Program on an annual basis through internal and external methods of evaluation.

III. PROCEDURE

A. The Office of Compliance shall utilize an independent third-party to conduct an evaluation of the effectiveness of the CalOptima Health Compliance Program on an annual basis.

B. CalOptima Health shall routinely monitor overall compliance effectiveness through, at least quarterly, dashboard reports and Audit and Monitoring results.

C. The Office of Compliance shall present the compliance effectiveness results to the Compliance Committee and the Governing Body at least annually.

D. The Office of Compliance shall review the compliance effectiveness results and include Audit findings/results in the annual Compliance work plan, as applicable.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Compliance Plan

C. Medicare Managed Care Manual, Chapter 21
D. Medicare Prescription Drug Benefit Manual, Chapter 9
E. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)
F. Title 42, Code of Federal Regulations (C.F.R.), §§422.504(b)(4)(vi)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Health Board of Directors
12/07/2017	Regular Meeting of the CalOptima Health Board of Directors
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12/05/2019	Regular Meeting of the CalOptima Health Board of Directors
12/03/2020	Regular Meeting of the CalOptima Health Board of Directors
12/20/2021	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	11/01/2014	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare
Revised	09/01/2015	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9116	Annual Compliance Program Effectiveness Audit	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2029Δ	Annual Compliance Program Effectiveness Audit	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2029	Annual Compliance Program Effectiveness Audit	OneCare
Retirement	09/01/2023	HH.2029	Annual Compliance Program Effectiveness Audit	OneCare

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Policy:	HH.3020
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	
Effective Date:	07/01/2007
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personal Information (PHI/PI) and/or other unauthorized access, Use, or Disclosure of PHI/PI to its regulators and providing notice to affected ~~m~~M~~M~~Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use or Disclosure of PHI/PI, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/PI, or other unauthorized access, Use or Disclosure of PHI/PI to regulators, as required by its regulatory contracts and applicable state and federal laws.

Back to Item

Back to Agenda

E. CalOptima Health shall notify individual Members whose Unsecured PHI/PI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PI, -and/or other unauthorized access, Use, or Disclosure of PHI/PI in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PI or other unauthorized access, Use, or Disclosure of PHI/PI involves DHCS and/or CalOptima Health PHI/PI.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a~~n~~ Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any -Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately and no later than twenty-four (24) hours from time of~~after~~ discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or PI;

      ii. Posting PHI or PI on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an

Back to Item

Back to Agenda

unintended third party due to incorrect fax numbers or emails; and

viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of ~~upon the~~ discovery of a suspected Bbreach, ~~or security~~ Security ~~incident~~ Incident, or unauthorized access, ~~use~~Use, or disclosure ~~-~~that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal ~~by email upon discovery of the Breach~~. If CalOptima Health is unable to provide notification ~~by email or~~ via the DHCS Privacy Incident Reporting Portal~~reporting portal~~, then CalOptima Health shall provide notice by email or telephone to DHCS.

b. CalOptima Health shall notify DHCS within twenty-four (24) hours ~~by email or~~ via the DHCS Privacy Incident Reporting Portal ~~reporting portal~~ (~~or~~ by email or telephone if necessary) of the discovery of:

i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

ii. Any suspected ~~security~~ Security ~~incident~~ Incident which risks unauthorized access to PHI and/or other confidential information;

iii. Any ~~intrusion~~Intrusion or unauthorized access, ~~use~~Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

c. Notice shall be made ~~using the current~~via the DHCS ~~"~~Privacy Incident Reporting Portal" ~~Form~~ and shall include all information known at the time the incident is reported.

d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer ~~by electronic mail, or by~~via the DHCS Privacy Incident Reporting Portal ~~reporting portal~~ (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy

Back to Item
Back to Agenda

Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal ~~Privacy Incident Report Form, or by using the DHCS reporting portal~~.

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from ~~after~~ the date of discovery, which is the first day the Breach is known by a Covered Entity, ~~or~~ or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the extent possible:

   a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

   b. A description of the types of Unsecured PHI/PI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

   c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

   d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

   e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

   a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

      i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

      ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima Health deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/PI, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PI as follows:

1. For Breaches of Unsecured PHI/PI involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PI involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

E. Security Incidents, Breaches, or unauthorized access, U~~u~~se, or disclosures of PHI/PII involving Medicare Members must be reported to the CMS IT Service Desk (CMS_IT_Service_desk@cms.hhs.gov) within one (1) hour of initial discovery using the "CMS Security and Privacy Incident Report Form". ~~-~~CalOptima Health shall copy the Regulatory Affairs and Compliance (RAC) Medicare ~~-~~and the CMS Account Manager when making the initial report. ~~-~~CalOptima Health shall work with the CMS Incident Management Team (IMT) to update the report as the incident is resolved.

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories.

G. For a Breach of Unsecured PHI/PI affecting more than five hundred (500) individuals, CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty

Back to Item
Back to Agenda

(60) calendar days from the date of discovery.

H. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

   a. Document the statement, including the identity of the official making the statement; and

   b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.G.1. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

~~I. DHCS Privacy Incident Report Form~~
A. HIPAA Violation Guidelines Matrix
~~A.~~B. CMS Security and Privacy Incident Report Form

V. REFERENCE(S)

A. CalOptima Health Business Associates Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Privacy Program
F. CalOptima Health Compliance Plan
G. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
H. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
I. MMCD All Plan Letter 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
J. MMCD All Plan Letter 06-005: Protected Health Information (PHI) and Notification of Breaches
K. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
~~K.~~L. Title 45, Code of Federal Regulations §164.400 - 414 et seq.
~~L.~~M. Title 45, Code of Federal Regulations §164.502
~~M.~~N. Title 45, Code of Federal Regulations §164.514
~~N.~~O. Title 45, Code of Federal Regulations §164.530(e)(1)
~~O.~~P. Title 42 United State Code (U.S.C) §17932(h)
~~P.~~Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

Back to Item
Back to Agenda

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE

Back to Item
Back to Agenda

Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE

1

Back to Item
Back to Agenda

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. (iii) A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PI)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

1

Policy:	HH.3020
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Department:	Office of Compliance
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CEO Approval:	
Effective Date:	07/01/2007
Revised Date:	09/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personal Information (PHI/PI) and/or other unauthorized access, Use, or Disclosure of PHI/PI to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use or Disclosure of PHI/PI, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/PI, or other unauthorized access, Use or Disclosure of PHI/PI to regulators, as required by its regulatory contracts and applicable state and federal laws.

Back to Item

Back to Agenda

E. CalOptima Health shall notify individual Members whose Unsecured PHI/PI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PI or other unauthorized access, Use, or Disclosure of PHI/PI involves DHCS and/or CalOptima Health PHI/PI.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately and no later than twenty-four (24) hours from time of discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or PI;

      ii. Posting PHI or PI on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an

Back to Item

Back to Agenda

unintended third party due to incorrect fax numbers or emails; and

viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of discovery of a suspected Breach, Security Incident, or unauthorized access, Use, or disclosure that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal . If CalOptima Health is unable to provide notification via the DHCS Privacy Incident Reporting Portal, then CalOptima Health shall provide notice by email or telephone to DHCS.

b. CalOptima Health shall notify DHCS within twenty-four (24) hours via the DHCS Privacy Incident Reporting Portal (by email or telephone if necessary) of the discovery of:

i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

ii. Any suspected Security Incident which risks unauthorized access to PHI and/or other confidential information;

iii. Any Intrusion or unauthorized access, Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

c. Notice shall be made via the DHCS Privacy Incident Reporting Portal and shall include all information known at the time the incident is reported.

d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer via the DHCS Privacy Incident Reporting Portal (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal .

Back to Item
Back to Agenda

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from the date of discovery, which is the first day the Breach is known by a Covered Entity or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the extent possible:

   a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

   b. A description of the types of Unsecured PHI/PI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

   c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

   d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

   e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

   a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

      i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

      ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

      iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include

Back to Item
Back to Agenda

a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima Health deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/PI, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PI as follows:

1. For Breaches of Unsecured PHI/PI involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PI involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

E. Security Incidents, Breaches, or unauthorized access, Use, or disclosures of PHI/PII involving Medicare Members must be reported to the CMS IT Service Desk (CMS_IT_Service_desk@cms.hhs.gov) within one (1) hour of initial discovery using the "CMS Security and Privacy Incident Report Form". CalOptima Health shall copy the Regulatory Affairs and Compliance (RAC) Medicare and the CMS Account Manager when making the initial report. CalOptima Health shall work with the CMS Incident Management Team (IMT) to update the report as the incident is resolved.

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories.

G. For a Breach of Unsecured PHI/PI affecting more than five hundred (500) individuals, CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

H. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health shall take the following action:

Back to Item
Back to Agenda

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

   a. Document the statement, including the identity of the official making the statement; and

   b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.G.1. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

A. HIPAA Violation Guidelines Matrix
B. CMS Security and Privacy Incident Report Form

V. REFERENCE(S)

A. CalOptima Health Business Associates Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Privacy Program
F. CalOptima Health Compliance Plan
G. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
H. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
I. MMCD All Plan Letter 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
J. MMCD All Plan Letter 06-005: Protected Health Information (PHI) and Notification of Breaches
K. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
L. Title 45, Code of Federal Regulations §164.400 - 414 et seq.
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 45, Code of Federal Regulations §164.530(e)(1)
P. Title 42 United State Code (U.S.C) §17932(h)
Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted

Back to Item
Back to Agenda

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE

Back to Item
Back to Agenda

Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE

1

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. (iii) A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PI)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

1

HIPAA Violation Guidelines Matrix

Violations of Privacy or Security of Protected Health Information (PHI) Or Other Confidential Information

The HIPAA (Health Insurance Portability and Accountability Act) Violation Guidelines Matrix is intended to be used as a guide for selecting the appropriate level of corrective action for policy and/or regulatory violations. The Guidelines include specific examples of violations or breaches of HIPAA/Privacy regulations.

Therefore, the following are guidelines for potential corrective action for violations of HIPAA/Privacy regulations and related CalOptima Health policies. The offenses listed are not an exhaustive list of violations or possible corrective actions that may be taken. CalOptima Health may elect to follow the Guidelines, skip any of the steps, or immediately terminate an employee, as all CalOptima Health employees are at-will. Nothing in these guidelines modifies – or should be interpreted to modify – the at-will employment status of employees. As at-will employees, CalOptima Health employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time, with or without cause, and with or without notice. (CalOptima Health Policy GA.8022: Performance and Behavior Standards).

CalOptima Health will evaluate the facts and circumstances of each incident on a case-by-case basis and will consider the severity and potential harm associated with each incident. The Office of Compliance and Human Resources will review all cases before corrective action is implemented. The Legal Affairs Office will review termination cases before implemented.

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level I	• Misdirected faxes, emails & mail. • Failure to log -off or lock a computer containing PHI when leaving the computer unattended. • Leaving paper PHI unattended in a publicly accessible area. • Dictating or discussing PHI in a non-secure area (lobby, hallway, cafeteria, and elevator). • Sending PHI from a CalOptima Health email account to an outside entity without using "send secure". • Storing files with PHI on a public network folder without a password.	• First Offense - Verbal Coaching/Coaching Memo • Second Offense - Documented Counseling Memo • Repeated Offenses – Further corrective action up to and including termination • Notify Privacy Officer of all incidents immediately • Repeat HIPAA and Information Security Online Training	**Mitigating Factors** • The recipient was a covered entity and attested to shredding/deleting/destroying the information. • The PHI was retrieved, deleted or made inaccessible **before it was viewed** (opened, read) by an unauthorized individual. • Employee self-reported incident after mistake occurred. • Employee has a legitimate business reason for transmitting/disclosing the PHI. • This was a first-time violation.

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level II	• Improper disposal of PHI. • Transmission of PHI/Confidential information to or from a personal email account without proper encryption, impacting fewer than 500 members. • For teleworkers, printing member PHI to a non-CalOptima Health issued printer. • Inappropriately sharing ID/password with others (e.g., co-workers or friends & family) or encouraging others to share ID/password. • Leaving laptops, cell phones, portable electronic devices unattended when traveling. • Failing to properly verify that an individual is authorized to manage the member's PHI on the phone before disclosing PHI.	• First Offense - Documented Counseling Memo/Final Written Warning • Second Offense - Termination, certain mitigating/aggravating factors may be considered for outcome of corrective action, including, but not limited to: 1. Documentation of training 2. Prior counseling(s)/corrective action • Notify Privacy Officer and Chief Information Officer	**Aggravating Factors** • The recipient of the PHI is unknown or is an individual who may have reason/cause to use the information in a malicious or harmful manner or for personal/financial gain. • The information disclosed/ accessed could not be retrieved/returned/shredded. This would include situations where PHI is sent via email and the email was opened. • The information accessed or disclosed included sensitive data (i.e., mental/behavioral health data, substance abuse, STD/HIV information) or financial data (HICN, SSN, bank account numbers, etc.). • The number of members impacted is more than 500. • The employee was deceptive or uncooperative during the investigation or regarding disclosure or access of PHI. • The employee has previously received training or corrective actions for a prior or similar violation. • The current misconduct found or acknowledged by the employee evidences multiple acts of wrongdoing or demonstrates a pattern of misconduct. • The violation occurred during the employee's resignation period. • There was no legitimate business reason for the employee to transmit and/or disclose the PHI.
Level III	• Requesting another coworker to inappropriately access and/or disclose PHI. • Intentionally accessing or allowing access to PHI without having a legitimate business reason and authorization. • Accessing member information such as a family member, friend, neighbor, coworker due to curiosity or concern. • Posting PHI to social media absent any aggravating factor. • Downloading/Uploading PHI/PII to external non-approved share site, website or external storage sites without	• Termination-no mitigation • Notify Privacy Officer and Chief Information Officer.	

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
	prior written authorization from IS and business leaders. • Intentionally or with gross negligence, downloads malware onto CalOptima Health's system that may result in a reported security breach incident. • Failure to report a breach, retaliating for reporting a breach, or hampering an investigation of a breach.		
Level IV	• Accessing or disclosing PHI or PII for financial or personal gain. • Malicious disclosure or malicious use of PHI. • Tampering with, modification of, and/or unauthorized destruction of PHI. • Falsifying documentation. • Posting PHI to social media in conjunction with any aggravating factor. • Acts that result in criminal or civil prosecution, where appropriate.	• Termination – no mitigation • Violation will be reported to licensing boards, law enforcement and/or third-party agencies, where appropriate or required. • Notify Privacy Officer and Chief Information Officer	

CMS Security and Privacy Incident Report

INSTRUCTIONS: This report Section 1 shall be completed to the extent possible by the person reporting or involved in a security or privacy incident (or their manager/supervisor). The report should be sent by email to *CMS_IT_Service_desk@cms.hhs.gov*. The Reporting Individual should collaborate with the CMS Incident Management Team (IMT) to update this report as the incident is resolved.

If the Reporting Individual does not initially have enough information to complete the report at this time, fill out as much as possible. DO NOT DELAY reporting this or any other incident, even if the incident is not yet confirmed. All suspected information security and privacy incidents must be reported to the CMS IT Service Desk within one hour of initial detection.

Section 1: Incident Information

(This section to be completed by the Reporting Individual to the extent possible at the time of the report.)

Date/Time of Initial Report:
Date/Time Activity First Detected:
Incident Tracking Number:

Reporting Individual Contact Information			
First Name	**Last Name**	**Email**	
Office Number	**Cell Number**	**Dept/OPDIV**	**UserID**

PII/PHI Breach Information	
Is PII/PHI suspected to be compromised (Yes/No)?	
(If Yes) Estimated Total Number of PII/PHI Records Impacted:	
(If Yes) Estimated Total Number of Users Impacted:	

Incident Description *(Please describe the incident. This section should be updated as the incident is handled.)*	**Last Update Date/Time**
How was this incident detected/discovered?	

Back to Item

Back to Agenda

What triage/analysis has been performed?	
Is the incident contained? How?	
What recovery/remediation action has taken place?	

Section 2: Estimated Incident Impact (Optional)

(This section is optional, intended for security personnel to complete where possible.)

Impacted FISMA System Information *(If more than one FISMA system is impacted, fill out a copy of this table for each system)*					
FISMA System Name					
FISMA System Officials					
Official	**First Name**	**Last Name**	**Email**	**Cell Number**	**Notified?**
Business Owner					
Information System Security Officer					
Other:					

Functional Impact

☐ No Impact
☐ No Impact to Services
☐ Minimal Impact to Non-Critical Services
☐ Minimal Impact to Critical Services
☐ Significant Impact to Non-Critical Services
☐ Denial of Non-Critical Services
☐ Significant Impact to Critical Services
☐ Denial of Critical Services/Loss of Control

Information Impact

☐ No Impact
☐ Suspected But Not Identified
☐ Privacy Data Breach
☐ Proprietary Information Breach
☐ Destruction of Non-Critical Systems
☐ Critical Systems Data Breach
☐ Core Credential Compromise
☐ Destruction of Critical System

Recoverability

☐ Regular
☐ Supplemented
☐ Extended
☐ Not Recoverable

Attack Vector

☐ Unknown
☐ External/Removable Media
☐ Improper Usage
☐ Loss or Theft of Equipment
☐ Impersonation/Spoofing
☐ Attrition
☐ Web
☐ Email/Phishing
☐ Other

Location of Observed Activity

☐ L1 – Business Demilitarized Zone
☐ L2 – Business Network
☐ L3 – Business Network Mgmt
☐ L4 – Critical System DMZ
☐ L5 – Critical System Mgmt
☐ L6 – Critical Systems
☐ L7 – Safety Systems
☐ – Unknown

Policy:	HH.3023p
Title:	**Information Sharing**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's process to share information with participating First Tier, Downstream, and Related Entities (FDRs), local health jurisdictions, and county and/or other public agencies for purposes of coordinating Medicare and Medi-Cal Covered Services between settings of care.

II. POLICY

A. CalOptima Health shall participate in data sharing exchanges, such as health information exchanges and community information exchanges, that permit the sharing of Personally Identifiable Information (PII) and/or Protected Health Information (PHI), as defined by the California Health and Human Services Data Exchange Framework (DxF) and in accordance with Health & Safety (H&S) Code section 130290. CalOptima Health shall comply with federal and state privacy laws and each data sharing agreement, as applicable.

B. CalOptima Health shall execute the DxF Data Sharing Agreement (DSA) on or before January 31, 2023. By January 31, 2024, CalOptima Health shall exchange health and social services information or provide access to health information as specified in the DSA and its policies and procedures.

C. CalOptima Health shall integrate disparate information to support the California Advancing and Innovating Medi-Cal (CalAIM) and Population Health Management (PHM) programs by performing key PHM functions and providing authorized users with access to timely, accurate, and comprehensive data on Member's health history and needs.

D. CalOptima Health interoperability shall enhance PHM services, in support of population health principals, integrated care and care coordination across delivery systems.

E. CalOptima Health shall integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members.

F. CalOptima Health shall share the United States Core Data for Interoperability (USCDI) as specified in Title 45 Code of Federal Regulations (CFR) 170.213, as necessary, to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the Department of Health Care Services (DHCS).

Back to Item

Back to Agenda

G. CalOptima Health shall exchange necessary data to implement Continuity of Care (CoC) protections.

H. CalOptima Health shall provide the DHCS with administrative, clinical, and other data requirements as specified by DHCS when requested.

I. Disclosure of PII/PHI for treatment, payment, and/or health care operations is permitted under many circumstances; however, to the extent required by applicable law, CalOptima Health shall not disclose PII/PHI unless a legally valid authorization from the subject Member of that PII/PHI has been obtained.

J. CalOptima Health shall adhere to stricter patient confidentiality laws when it applies and, when applicable, the federal substance use disorder confidentiality regulation, 42 CFR Part 2.

K. When information may be shared under HIPAA and other applicable laws, CalOptima Health may share only the minimum information necessary to accomplish the purpose of the disclosure, pursuant to CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

L. Where a Business Associate Agreement (BAA) applies, CalOptima Health's BAA template must be effectuated before sharing PII and/or PHI with an external party, pursuant to CalOptima Health Policy HH.3022: Business Associate Agreements.

M. A Member may request to restrict or limit information sharing in accordance with applicable statutory, regulatory, and contractual requirements, as permissible under CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information.

III. PROCEDURE

A. CalOptima Health shall provide the following information to Enhanced Care Management (ECM) Providers:

1. Member assignment files, which include listing of Members authorized and assigned to the ECM Provider;

2. Historical encounters/claims data for assigned Members;

3. Physical, behavioral and administrative information, and information indicating Member Social Drivers of Health (SDOH) needs;

4. Reports of performance on quality measures, as requested.

B. Admission, Discharge, and Transfer (ADT) information

1. CalOptima Health shall require contracted Hospitals and Skilled Nursing Facilities (SNFs) to provide timely notifications of Member admissions, discharges, and/or transfers (ADT). Hospital and SNF information shall be exchanged in shared information systems.

2. CalOptima Health shall maintain contracts with vendors to supply ADT messages in support of this policy.

a. Hospitals shall notify CalOptima Health of ADT information either immediately, prior to, or at the time of the Member's discharge or transfer from the Hospital's inpatient services.

b. For SNF admissions, the SNF shall notify CalOptima Health within 48 hours of admission.

c. For SNF discharges or transfers, the SNF shall notify CalOptima Health in advance if at all possible, or at the time of the discharge or transfer.

3. CalOptima Health shall ensure that data exchanged is appropriately linked to the correct, real person.

C. In accordance with all NCQA PHM standards, CalOptima Health shall exchange the following data to ensure the ability to assess the needs of all Members:

1. Medical and behavioral claims or encounters;

2. Pharmacy claims;

3. Laboratory results;

4. Health appraisal status;

5. Electronic health records; and

6. Health services programs within the organization

D. In accordance with California Penal Code Section 4011.11, disclosure of PII is permitted if the disclosure is:

1. Reasonably necessary to facilitate a county jail or youth correctional inmate's enrollment in CalOptima Health;

2. Reasonably necessary to facilitate a county jail or youth correctional inmate's behavioral health treatment post-release; and

3. Complies with federal laws.

E. External data sharing requests shall undergo CalOptima Health's data sharing review procedure.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

1. CalOptima Health Contract with Department of Health Care Services (DHCS)
2. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
3. CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information
4. CalOptima Health Policy HH.3022: Business Associate Agreements
5. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)

6. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide
7. CalAIM Enhanced Care Management Policy Guide, July 2023
8. CalAIM Data Sharing Authorization Guidance, March 2022
9. CalAIM D-SNP Policy Guide, June 2023
10. CalAIM Population Health Management Policy Guide, September 2022
11. Title 45 Code of Federal Regulations (CFR) 170.213
12. California Penal Code Section 4011.11

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	HH.3023	Information Sharing	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing, and home health care.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Enhanced Care Management (ECM) Provider	A Provider within the community that have a contractual relationship with CalOptima Health (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Member	A beneficiary enrolled in a CalOptima Health program.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including: 1. Any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and 2. Any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.

Term	Definition
Skilled Nursing Facility (SNF)	Medi-Cal: As defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility." OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

1

Policy:	HH.4002
Title:	**CalOptima Health Internal Oversight**
Department:	Office of Compliance
Section:	~~Audit & Oversight~~ Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines the process for I~~i~~nternal Monitoring and O~~o~~versight of CalOptima Health to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements.

II. POLICY

A. The ~~Audit & Oversight~~ Internal Audit Department shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The ~~Audit & Oversight~~ Internal Audit Department shall perform a (Monthly/Quarterly), and at least an ~~a~~Annual ~~r~~Risk ~~a~~Assessment, as outlined in CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal) and develop an A~~a~~nnual Internal Audit and Monitoring Work Plan.

1. The Annual ~~r~~Risk ~~a~~Assessment and Internal Audit and Monitoring Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Health Medi-Cal, OneCare, and PACE programs.

C. ~~Audit & Oversight~~ Internal Audit Department shall assess each of the CalOptima Health departments identified on the Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan). Each may be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the ~~Audit & Oversight~~ Internal Audit Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. ~~-~~The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of ~~the Audit & Oversight Delegation Oversight Committee (AOC DOC) and~~ the Compliance Committee.

E. The ~~Audit & Oversight~~ Internal Audit Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory

Audits, and shall Monitor performance to ensure performance meets applicable regulatory and industry standards. In the event Monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

G. Audits of CalOptima Health's internal functional areas will be conducted, at minimum, annually by desktop review and by on-site review and/or webinar. CalOptima Health shall ensure audits are conducted at reasonable times.

H. CalOptima Health's ~~Audit & Oversight~~ Internal Audit Department shall maintain documentation of Internal Oversight activities described herein.

I. The Auditing and Monitoring results shall be reported to the ~~AOC~~ ~~DOC, and the~~ Compliance Committee for review and recommendations. When appropriate, CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm or impact the delivery of care to CalOptima Health Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policies, or other requirements to CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. CalOptima Health shall conduct activities in accordance with the terms and conditions of CalOptima Health regulatory requirements, CalOptima Health policies and procedures, CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews, and Audits and Monitoring;

3. Periodic reviews and Audits; and

4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;

2. Utilization Management;

3. Claims processing/adjudication and payment timeliness;

4. Provider disputes and claim appeals;

5. Member rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions~~.; and~~;

15. Reporting and Monitoring~~.~~ ; and

~~15.~~16. Other functional areas identified by the Annual Risk Assessment as having potential for high or medium risk.

D. The ~~Audit & Oversight~~ Internal Audit Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The ~~Audit & Oversight~~ Internal Audit Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the ~~Audit & Oversight~~ Internal Audit Department shall identify and schedule Audits as a result of the ~~a~~Annual ~~r~~Risk ~~a~~Assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima Health policies and procedures.

3. Two (2) weeks prior to the scheduled Audit, the ~~Audit & Oversight~~ Internal Audit Department will send, via email, the CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the due date, method of delivery, and Audit format. The ~~Audit & Oversight~~ Internal Audit Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned ~~Audit & Oversight~~ Internal Audit auditor shall select a sample size, as determined by ~~Audit & Oversight~~ Internal Audit, that is appropriate for the type of Audit being conducted, such as:

a. Processes considered to be high-risk and/or have potential Member harm;

b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the Audit period or request additional information, or documentation.

6. The ~~Audit & Oversight~~ Internal Audit auditor will notify the CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

   a. The ~~Audit & Oversight~~ Internal Audit auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

   b. The ~~Audit & Oversight~~ Internal Audit auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe (s).

8. The ~~Audit & Oversight~~ Internal Audit auditor shall discuss findings from the annual Audit with the respective CalOptima Health department and document such findings in an Audit finding report. If any CalOptima Health department receives a score of less than the established passing score for an individual audit element, the department will be required to develop a Corrective Action Plan in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

   a. The ~~Audit & Oversight~~ Internal Audit auditor is responsible for confirming remediation or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation. The ~~Audit & Oversight~~ Internal Audit management or auditor shall report the findings of the audit, CAPs, if any, and the timeline for CAP remediation to ~~the~~ the Compliance Committee.~~AOC~~ ~~DOC.~~

9. Audit findings will be presented to the Compliance Committee ~~AOC DOC~~ by the ~~Audit & Oversight~~ Internal Audit Department for the respective functional area reviewed. The ~~Audit & Oversight~~ Internal Audit Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the ~~Audit & Oversight~~ Internal Audit auditor.

10. A department must resolve the elements of the CAP in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

11. In the event the elements of the CAP are not successfully completed within the established timeframe, the Director of ~~Audit & Oversight~~ Internal Audit shall report status to the Compliance Committee ~~AOC DOC~~ following the CAP period. The ~~AOC DOC~~ Compliance Committee will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

a. The ~~Audit & Oversight~~ Internal Audit Department must demonstrate to the Compliance Committee ~~AOC DOC~~ the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The ~~Audit & Oversight~~ Internal Audit Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of~~-~~ identified issues. Issues escalated will be reviewed by the ~~Audit & Oversight~~ Internal Audit Department, ~~AOC DOC,~~ and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The ~~Audit & Oversight~~ Internal Audit Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the ~~a~~Annual ~~r~~Risk ~~a~~Assessment, and as outlined on the Internal Audit and Monitoring Work Plan.

2. Internal Key Performance Indicators/~~-~~Dashboard Reporting: On a monthly basis, data shall be used to Monitor areas for processing timeliness~~, and~~ accuracy of business ~~activities~~activities, goals, and measures~~.~~

a. The ~~AOC DOC~~ Internal Audit Department ~~shall~~ shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the ~~AOC DOC~~ Compliance Committee.

b. If there is a consistent pattern of non-compliance, the ~~Audit & Oversight~~ Internal Audit Department shall conduct a Focused Review.

i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to the Compliance Committee for disciplinary action and/or development of remediation plan.

G. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the ~~Audit & Oversight~~ Internal Audit Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4003: Annual Risk Assessment
G. Title 42, Code of Federal Regulations (C.F.R.), §455.2

H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/05/2019	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/20/2021	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/31/2022	HH.4002	CalOptima Health Internal Oversight	Administrative
Revised	09/01/2023	HH.4002	CalOptima Health Internal Oversight	Administrative

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in~~:~~ unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
~~Annual Risk Assessment Tool~~	~~A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.~~ ~~A screening tool to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment tool includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.~~
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
~~Audit & Delegation Oversight Committee (AOCDOC)~~	~~A subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the AOC DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Audit & Delegation Oversight Committee.~~
Business Owner	CalOptima Health management and staff vested in the compliance of their respective CalOptima Health functional area in accordance with statutory, regulatory, contractual, and CalOptima Health policy requirements.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and ~~Executive Director of Human Resources~~Chief Human Resources Officer.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Term	Definition
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima Health's ~~Audit and Oversight~~ Internal Audit Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima Health policy requirements to ensure health plan compliance.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Risk Assessment Tool	A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.4002
Title:	**CalOptima Health Internal Oversight**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines the process for Internal Monitoring and Oversight of CalOptima Health to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements.

II. POLICY

A. The Internal Audit Department shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The Internal Audit Department shall perform a (Monthly/Quarterly), and at least an Annual Risk Assessment, as outlined in CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal) and develop an Annual Internal Audit and Monitoring Work Plan.

1. The Annual Risk Assessment and Internal Audit and Monitoring Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Health Medi-Cal, OneCare, and PACE programs.

C. Internal Audit Department shall assess each of the CalOptima Health departments identified on the Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan). Each may be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the Internal Audit Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of the Compliance Committee.

E. The Internal Audit Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, and shall Monitor performance to ensure performance meets applicable regulatory and industry standards. In the event

Monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

G. Audits of CalOptima Health's internal functional areas will be conducted, at minimum, annually by desktop review and by on-site review and/or webinar. CalOptima Health shall ensure audits are conducted at reasonable times.

H. CalOptima Health's Internal Audit Department shall maintain documentation of Internal Oversight activities described herein.

I. The Auditing and Monitoring results shall be reported to the Compliance Committee for review and recommendations. When appropriate, CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm or impact the delivery of care to CalOptima Health Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policies, or other requirements to CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. CalOptima Health shall conduct activities in accordance with the terms and conditions of CalOptima Health regulatory requirements, CalOptima Health policies and procedures, CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;
2. Focused and ad hoc reviews, and Audits and Monitoring;
3. Periodic reviews and Audits; and
4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;
2. Utilization Management;
3. Claims processing/adjudication and payment timeliness;
4. Provider disputes and claim appeals;

5. Member rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions.;

15. Reporting and Monitoring ; and

16. Other functional areas identified by the Annual Risk Assessment as having potential for high or medium risk.

D. The Internal Audit Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The Internal Audit Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Internal Audit Department shall identify and schedule Audits as a result of the Annual Risk Assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima Health policies and procedures.

3. Two (2) weeks prior to the scheduled Audit, the Internal Audit Department will send, via email, the CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the due date, method of delivery, and Audit format. The Internal Audit Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Internal Audit auditor shall select a sample size, as determined by Internal Audit, that is appropriate for the type of Audit being conducted, such as:

a. Processes considered to be high-risk and/or have potential Member harm;

b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the Audit period or request additional information, or documentation.

6. The Internal Audit auditor will notify the CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

   a. The Internal Audit auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

   b. The Internal Audit auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe (s).

8. The Internal Audit auditor shall discuss findings from the annual Audit with the respective CalOptima Health department and document such findings in an Audit finding report. If any CalOptima Health department receives a score of less than the established passing score for an individual audit element, the department will be required to develop a Corrective Action Plan in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

   a. The Internal Audit auditor is responsible for confirming remediation or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation. The Internal Audit management or auditor shall report the findings of the audit, CAPs, if any, and the timeline for CAP remediation to the Compliance Committee.

9. Audit findings will be presented to the Compliance Committee by the Internal Audit Department for the respective functional area reviewed. The Internal Audit Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Internal Audit auditor.

10. A department must resolve the elements of the CAP in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

11. In the event the elements of the CAP are not successfully completed within the established timeframe, the Director of Internal Audit shall report status to the Compliance Committee following the CAP period. The Compliance Committee will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

    a. The Internal Audit Department must demonstrate to the Compliance Committee the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Internal Audit Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of identified issues. Issues escalated will be reviewed by the Internal Audit Department, and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The Internal Audit Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the Annual Risk Assessment, and as outlined on the Internal Audit and Monitoring Work Plan.

2. Internal Key Performance Indicators/Dashboard Reporting: On a monthly basis, data shall be used to Monitor areas for processing timeliness, accuracy of business activities, goals, and measures

a. The Internal Audit Department shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the Compliance Committee.

b. If there is a consistent pattern of non-compliance, the Internal Audit Department shall conduct a Focused Review.

i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to the Compliance Committee for disciplinary action and/or development of remediation plan.

G. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Internal Audit Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4003: Annual Risk Assessment
G. Title 42, Code of Federal Regulations (C.F.R.), §455.2
H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/05/2019	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/20/2021	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/31/2022	HH.4002	CalOptima Health Internal Oversight	Administrative
Revised	09/01/2023	HH.4002	CalOptima Health Internal Oversight	Administrative

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Business Owner	CalOptima Health management and staff vested in the compliance of their respective CalOptima Health functional area in accordance with statutory, regulatory, contractual, and CalOptima Health policy requirements.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq.*
Focused Review	An audit that specifically targets areas of potential deficiency.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Term	Definition
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima Health's Internal Audit Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima Health policy requirements to ensure health plan compliance.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Risk Assessment Tool	A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	~~Audit & Oversight~~ Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health ~~Audit & Oversight~~ Internal Audit Department to identify specific areas vulnerable to potential compliance risk. ~~-~~Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The ~~Audit & Oversight~~ Internal Audit Department is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima Health. ~~-~~In assessing risk, the ~~Audit & Oversight~~ Internal Audit Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima Health's policies and procedures;
3. Business impact on Member care;
4. Past compliance issues (e.g., CAPs, Regulator Notices); and
5. Compliance dashboard results.

B. The ~~Audit & Oversight~~ Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The ~~Audit & Oversight~~ Internal Audit Department shall present ~~a~~Annual ~~r~~Risk ~~a~~Assessment results and the proposed Internal Audit and Monitoring Work Plan to the ~~Delegation Oversight Committee (DOC) and~~ Compliance Committee for review and approval by the end of the fiscal year to be effective for the following year.

III. PROCEDURE

A. The ~~Audit & Oversight~~ Internal Audit Department shall schedule meetings with all operational department leads in order to complete the assessment.

1. Discovery and Analysis. The ~~Audit & Oversight~~ Internal Audit Department shall undertake a discovery process to determine which regulatory, statutory, contractual, and CalOptima Health policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

    a. In order to determine whether there are accurate and compliant processes and systems in place, the ~~Audit & Oversight~~ Internal Audit Department shall conduct the following activities:

        i. A review of CalOptima Health policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the ~~Audit & Oversight~~ Internal Audit Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The ~~Audit & Oversight~~ Internal Audit Department shall evaluate the documents for compliance.

        ii. Schedule interviews with internal functional area department management and relevant support staff to discuss the following:

            a) Processes that are supported by policies and procedures and other relevant documentation;

            b) Changes in laws, or regulations, in the previous year that impact their area;

            c) Changes in management and staffing;

            d) The degree to which the activities conducted by their area impact CalOptima Health Members; and

            e) Material changes in processes that are expected to impact the functional areas.

B. The ~~Audit & Oversight~~ Internal Audit Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory Agencies identify a particular area as problematic through enforcement actions, CalOptima Health Audit findings, notices of non-compliance, etc.;

2. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliant area; and

3. CalOptima Health's Star Ratings scores for specific requirements, to be populated as applicable.

C. To validate compliance of the staff interviews, and review of other relevant information, the ~~Audit & Oversight~~ Internal Audit Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment Audits evaluating file reviews, data collected from annual Audit results, and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the ~~Audit & Oversight~~ Internal Audit Department shall compile the data and then ranks the risks based on the greatest impact.

D. The ~~Audit & Oversight~~ Internal Audit Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring Work Plan.

E. The ~~Audit & Oversight~~ Internal Audit Department shall present the internal risk assessment results and proposed Audit and Monitoring Work Plan following approval by the ~~Delegation Oversight Committee (DOC) and~~ Compliance Committee.

F. The ~~Audit & Oversight~~ Internal Audit Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal Audit results, Monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency Audits results, etc.).

G. Upon completion, results of the internal risk assessment are presented to the ~~Delegation Oversight Committee (DOC) and the~~ Compliance Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/07/2017	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/06/2018	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/05/2019	HH.4003	Annual Risk Assessment (Internal)	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/20/2021	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/31/2022	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	09/01/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative

1

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in ~~in:~~ unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being Audited and normally performed by individuals with one of several acknowledged certifications.
Annual Risk Assessment ~~Tool~~	~~A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima Health functional areas vulnerable to potential Compliance risk.~~ A screening to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Term	Definition
~~Delegation Oversight Committee (DOC)~~	~~A subcommittee of the Compliance Committee chaired by the Director of the Audit & Oversight~~ Delegation Oversight ~~Department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.~~
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the Audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, Regulatory Agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	09/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health Internal Audit Department to identify specific areas vulnerable to potential compliance risk. Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The Internal Audit Department is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima Health. In assessing risk, the Internal Audit Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima Health's policies and procedures;
3. Business impact on Member care;
4. Past compliance issues (e.g., CAPs, Regulator Notices); and
5. Compliance dashboard results.

B. The Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The Internal Audit Department shall present Annual Risk Assessment results and the proposed Internal Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the fiscal year to be effective for the following year.

III. PROCEDURE

A. The Internal Audit Department shall schedule meetings with all operational department leads in

order to complete the assessment.

1. Discovery and Analysis. The Internal Audit Department shall undertake a discovery process to determine which regulatory, statutory, contractual, and CalOptima Health policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

    a. In order to determine whether there are accurate and compliant processes and systems in place, the Internal Audit Department shall conduct the following activities:

        i. A review of CalOptima Health policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Internal Audit Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Internal Audit Department shall evaluate the documents for compliance.

        ii. Schedule interviews with internal functional area department management and relevant support staff to discuss the following:

            a) Processes that are supported by policies and procedures and other relevant documentation;

            b) Changes in laws, or regulations, in the previous year that impact their area;

            c) Changes in management and staffing;

            d) The degree to which the activities conducted by their area impact CalOptima Health Members; and

            e) Material changes in processes that are expected to impact the functional areas.

B. The Internal Audit Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory Agencies identify a particular area as problematic through enforcement actions, CalOptima Health Audit findings, notices of non-compliance, etc.;

2. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliant area; and

3. CalOptima Health's Star Ratings scores for specific requirements, to be populated as applicable.

C. To validate compliance of the staff interviews, and review of other relevant information, the Internal Audit Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment Audits evaluating file reviews, data collected from annual Audit results, and number of CAPs issued during the review period.

1. As data-driven analysis is significant to determine functional area risk to Members, the Internal

Audit Department shall compile the data and then ranks the risks based on the greatest impact.

D. The Internal Audit Department shall prioritize those with greatest risk when developing the annual Audit and Monitoring Work Plan.

E. The Internal Audit Department shall present the internal risk assessment results and proposed Audit and Monitoring Work Plan following approval by the Compliance Committee.

F. The Internal Audit Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal Audit results, Monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, regulatory agency Audits results, etc.).

G. Upon completion, results of the internal risk assessment are presented to the Compliance Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/07/2017	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/06/2018	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/05/2019	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/03/2020	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/20/2021	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/31/2022	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	09/01/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative

1

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being Audited and normally performed by individuals with one of several acknowledged certifications.
Annual Risk Assessment	A screening to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the Audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, Regulatory Agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Financial Summary

August 31, 2023

Board of Directors Meeting
October 5, 2023

Nancy Huang, Chief Financial Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Back to Agenda

Financial Highlights: August 2023

August 2023					July 2023 - August 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
990,241	975,932	14,309	1.5%	Member Months	1,969,859	1,968,354	1,505	0.1%
362,339,929	356,484,959	5,854,970	1.6%	Revenues	725,117,707	718,596,829	6,520,878	0.9%
332,037,328	333,387,752	1,350,424	0.4%	Medical Expenses	650,999,667	669,749,885	18,750,218	2.8%
17,317,218	21,182,575	3,865,357	18.2%	Administrative Expenses	34,102,163	41,194,042	7,091,879	17.2%
12,985,383	1,914,632	11,070,751	578.2%	Operatng Margin	40,015,877	7,652,902	32,362,975	422.9%
				Non-Operating Income (Loss)				
12,965,003	2,083,330	10,881,673	522.3%	Net Investment Income/(Loss)	27,182,774	4,166,660	23,016,114	552.4%
(18,558,950)	(21,003,219)	2,444,269	11.6%	Grant Income/(Expense)	(19,505,920)	(22,006,439)	2,500,519	11.4%
(530,403)	(32,713)	(497,690)	(1521.4%)	Other Income/(Expense)	(504,842)	(65,426)	(439,416)	(671.6%)
(6,124,349)	(18,952,602)	12,828,253	67.7%	Total Non-Operating Income (Loss)	7,172,012	(17,905,205)	25,077,217	140.1%
6,861,034	**(17,037,970)**	**23,899,004**	**140.3%**	**Change in Net Assets**	**47,187,889**	**(10,252,303)**	**57,440,192**	**560.3%**
91.6%	*93.5%*	*(1.9%)*		*Medical Loss Ratio*	*89.8%*	*93.2%*	*(3.4%)*	
4.8%	*5.9%*	*1.2%*		*Administrative Loss Ratio*	*4.7%*	*5.7%*	*1.0%*	

Back to Agenda

CalOptima Health

Financial Highlights Notes: August 2023

- Notable grant related events/items in August 2023
  - $12.5 million for Naloxone Distribution Event
  - $5.0 million for Stipend Program for California State University, Fullerton Master of Social Work Students

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) August 2023: $6.9 million, favorable to budget $23.9 million or 140.3% driven primarily by net investment income and favorable net enrollment
  - Year To Date (YTD) July - August 2023: $47.2 million, favorable to budget $57.4 million or 560.3% due to lower-than-expected utilization and net investment income

- Enrollment
  - MTD: 990,241 members, favorable to budget 14,309 or 1.5% due to a delay in disenrollment from a statewide system issue with the Department of Health Care Services (DHCS)
  - YTD: 1,969,859 member months, favorable to budget 1,505 or 0.1%

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $362.3 million, favorable to budget $5.9 million or 1.6% driven by Medi-Cal (MC) Line of Business (LOB) due to favorable enrollment and Student Behavioral Health Incentive Program (SBHIP)
  - YTD: $725.1 million, favorable to budget $6.5 million or 0.9% driven by MC LOB

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $332.0 million, favorable to budget $1.4 million or 0.4% driven by OneCare Connect (OCC) and PACE LOB's, offset by MC LOB
  - YTD: $651.0 million, favorable to budget $18.8 million or 2.8% driven by MC LOB:
    - Primarily due to lower-than-expected utilization in Facilities and Managed Long-Term Services and Supports (MLTSS) claims
    - Offset by unfavorable Incentive Payments

Back to Agenda

FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $17.3 million, favorable to budget $3.9 million or 18.20%
  - YTD: $34.1 million, favorable to budget $7.1 million or 17.2%

- Non-Operating Income (Loss)
  - MTD: ($6.1) million, favorable to budget $12.8 million or 67.7%
  - YTD: $7.2 million, favorable to budget $25.1 million or 140.1%

Back to Agenda

CalOptima Health

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 91.6%, Budget 93.5%
  - YTD: Actual 89.8%, Budget 93.2%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.8%, Budget 5.9%
  - YTD: Actual 4.7%, Budget 5.7%
- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.78
  - Net-position: $1.7 billion, including required Tangible Net Equity (TNE) of $108.2 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

Back to Agenda

Enrollment Summary: August 2023

Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
143,633	141,549	2,084	1.5%	SPD	286,452	284,153	2,299	0.8%
304,115	316,616	(12,501)	(3.9%)	TANF Child	606,022	635,964	(29,942)	(4.7%)
144,054	132,408	11,646	8.8%	TANF Adult	286,636	267,101	19,535	7.3%
2,992	3,118	(126)	(4.0%)	LTC	6,003	6,236	(233)	(3.7%)
365,611	352,762	12,849	3.6%	MCE	725,404	716,008	9,396	1.3%
11,589	11,372	217	1.9%	WCM	22,971	22,731	240	1.1%
971,994	**957,825**	**14,169**	**1.5%**	**Medi-Cal Total**	**1,933,488**	**1,932,193**	**1,295**	**0.1%**
17,815	**17,650**	**165**	**0.9%**	**OneCare**	**35,510**	**35,251**	**259**	**0.7%**
432	**457**	**(25)**	**(5.5%)**	**PACE**	**861**	**910**	**(49)**	**(5.4%)**
500	**568**	**(68)**	**(12.0%)**	**MSSP**	**1,003**	**1,136**	**(133)**	**(11.7%)**
990,241	**975,932**	**14,309**	**1.5%**	**CalOptima Total**	**1,969,859**	**1,968,354**	**1,505**	**0.1%**

*CalOptima Health Total does not include MSSP

Back to Agenda

CalOptima Health

Consolidated Revenue & Expenses: August 2023 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	606,383	365,611	971,994	17,815		432	500	990,241
REVENUES								
Capitation Revenue	191,788,544	$ 135,174,713	$ 326,963,257	$ 32,724,643	$ (1,323,639)	$ 3,762,531	$ 213,136	$ 362,339,929
Total Operating Reven	**191,788,544**	**135,174,713**	**326,963,257**	**32,724,643**	**(1,323,639)**	**3,762,531**	**213,136**	**362,339,929**
MEDICAL EXPENSES								
Provider Capitation	61,047,815	48,584,342	109,632,157	13,237,874				122,870,031
Claims	77,161,579	48,079,711	125,241,289	7,675,884	(32,744)	1,363,667		134,248,097
MLTSS	40,140,049	5,379,122	45,519,172	82,113	(2,352)	(989)	27,361	45,625,306
Prescription Drugs	(535)		(535)	9,100,466	(1,718,141)	449,623		7,831,413
Case Mgmt & Other Medic	10,952,353	8,040,336	18,992,689	1,112,022	8,409	1,177,016	172,343	21,462,481
Total Medical Expense	**189,301,262**	**110,083,511**	**299,384,773**	**31,208,360**	**(1,744,827)**	**2,989,318**	**199,705**	**332,037,328**
Medical Loss Ratio	*98.7%*	*81.4%*	*91.6%*	*95.4%*	*131.8%*	*79.4%*	*93.7%*	*91.6%*
GROSS MARGIN	**2,487,283**	**25,091,202**	**27,578,485**	**1,516,283**	**421,188**	**773,214**	**13,431**	**30,302,601**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,232,789	1,073,610	(0)	162,537	82,645	12,551,582
Non-Salary Operating Expenses			1,073,922	292,787		17,289	1,346	1,385,344
Depreciation & Amortization			915,256			1,103		916,360
Other Operating Expenses			2,025,731	38,499		13,195	6,904	2,084,329
Indirect Cost Allocation, Occupancy			(591,276)	948,600		14,749	7,530	379,603
Total Administrative Expenses			**14,656,422**	**2,353,496**	**(0)**	**208,874**	**98,426**	**17,317,218**
Administrative Loss Ratio			*4.5%*	*7.2%*	*0.0%*	*5.6%*	*46.2%*	*4.8%*
Operating Income/(Loss)			**12,922,062**	**(837,213)**	**421,189**	**564,339**	**(84,994)**	**12,985,383**
Investments and Other Non-Operating			(538,177)					(6,124,349)
CHANGE IN NET ASSETS			**$ 12,383,886**	**$ (837,213)**	**$ 421,189**	**$ 564,339**	**$ (84,994)**	**$ 6,861,034**
BUDGETED CHANGE IN NET ASSETS			4,479,239	(2,463,093)	-	(25,663)	(75,851)	(17,037,970)
Variance to Budget - Fav/(Unfav)			$ 7,904,647	$ 1,625,880	$ 421,189	$ 590,002	$ (9,143)	$ 23,899,004

Back to Agenda

CalOptima Health

Consolidated Revenue & Expenses: August 2023 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	1,208,084	725,404	1,933,488	35,510		861	1,003	1,969,859
REVENUES								
Capitation Revenue	385,530,193	$ 269,584,631	$ 655,114,824	$ 63,471,316	$ (1,263,173)	$ 7,359,768	$ 434,973	$ 725,117,707
Total Operating Reven	**385,530,193**	**269,584,631**	**655,114,824**	**63,471,316**	**(1,263,173)**	**7,359,768**	**434,973**	**725,117,707**
MEDICAL EXPENSES								
Provider Capitation	121,915,757	98,027,534	219,943,291	25,632,094				245,575,385
Claims	144,014,564	92,730,534	236,745,098	15,059,059	(63,740)	2,959,800		254,700,217
MLTSS	79,680,141	10,410,074	90,090,215	163,904	(4,286)	(21,204)	42,336	90,270,965
Prescription Drugs	(9,025)		(9,025)	16,909,516	(1,718,348)	868,475		16,050,618
Case Mgmt & Other Medic	23,135,565	16,560,400	39,695,966	2,076,618	38,939	2,282,805	308,154	44,402,482
Total Medical Expense	**368,737,002**	**217,728,542**	**586,465,544**	**59,841,190**	**(1,747,435)**	**6,089,877**	**350,490**	**650,999,667**
Medical Loss Ratio	*95.6%*	*80.8%*	*89.5%*	*94.3%*	*138.3%*	*82.7%*	*80.6%*	*89.8%*
GROSS MARGIN	**16,793,191**	**51,856,089**	**68,649,280**	**3,630,126**	**484,262**	**1,269,891**	**84,483**	**74,118,041**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			21,315,546	2,083,442	(0)	303,306	205,993	23,908,288
Non-Salary Operating Expenses			3,240,770	591,465	(4,253)	38,673	2,686	3,869,342
Depreciation & Amortization			1,756,464			2,189		1,758,654
Other Operating Expenses			3,715,286	97,698		20,430	7,027	3,840,441
Indirect Cost Allocation, Occupancy			(1,216,229)	1,897,200		29,409	15,060	725,440
Total Administrative Expenses			**28,811,838**	**4,669,805**	**(4,253)**	**394,008**	**230,766**	**34,102,163**
Administrative Loss Ratio			*4.4%*	*7.4%*	*0.3%*	*5.4%*	*53.1%*	*4.7%*
Operating Income/(Loss)			**39,837,442**	**(1,039,679)**	**488,515**	**875,883**	**(146,284)**	**40,015,877**
Investments and Other Non-Operating			(538,177)					7,172,012
CHANGE IN NET ASSETS			**$ 39,299,265**	**$ (1,039,679)**	**$ 488,515**	**$ 875,883**	**$ (146,284)**	**$ 47,187,889**
BUDGETED CHANGE IN NET ASSETS			12,377,559	(4,651,004)	-	70,405	(144,058)	(10,252,303)
Variance to Budget - Fav/(Unfav)			$ 26,921,706	$ 3,611,325	$ 488,515	$ 805,478	$ (2,226)	$ 57,440,192

Back to Agenda

CalOptima Health

Balance Sheet: As of August 2023

ASSETS	
Current Assets	
Operating Cash	$696,603,705
Short-term Investments	1,826,657,374
Receivables & Other Current Assets	440,201,716
Total Current Assets	**2,963,462,795**
Capital Assets	
Capital Assets	153,725,768
Less Accumulated Depreciation	(69,081,345)
Capital Assets, Net of Depreciation	84,644,423
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	581,015,968
Total Other Assets	**581,315,968**
TOTAL ASSETS	**3,629,423,186**
Deferred Outflows	**25,969,350**
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,655,392,536**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$13,950,826
Medical Claims Liability and Capitation Payable	1,652,052,289
Capitation and Withholds	134,171,890
Other Current Liabilities	52,798,891
Total Current Liabilities	**1,852,973,897**
Other Liabilities	
GASB 96 Subscription Liabilities	14,520,742
Postemployment Health Care Plan	19,063,095
Net Pension Liabilities	40,465,145
Total Other Liabilities	**74,048,981**
TOTAL LIABILITIES	**1,927,022,878**
Deferred Inflows	**11,175,516**
Net Position	
TNE	108,217,951
Funds in Excess of TNE	1,608,976,192
TOTAL NET POSITION	**1,717,194,142**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,655,392,536**

Back to Agenda

CalOptima Health

Board Designated Reserve and TNE Analysis: As of August 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,895,290				
	Tier 1 - MetLife	235,039,626				
Board Designated Reserve		471,934,916	349,766,729	546,045,878	122,168,187	(74,110,962)
	Tier 2 - Payden & Rygel	54,679,671				
	Tier 2 - MetLife	54,401,381				
TNE Requirement		109,081,053	108,217,951	108,217,951	863,102	863,102
	Consolidated:	**581,015,968**	**457,984,680**	**654,263,829**	**123,031,288**	**(73,247,860)**
	Current reserve level	*1.78*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health

Net Assets Analysis: As of August 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 8/31/2023	**$1,717.2**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**581.0**			**33.8%**
	Capital Assets, net of Depreciation[2]	**84.6**			**4.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$19.9	$59.9	$40.0	1.2%
	Housing and Homelessness Initiative Program[4]	69.7	97.2	27.5	4.1%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.4%
	Digital Transformation and Workplace Modernization[5]	71.3	100.0	28.7	4.2%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.8	8.0	1.2	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.3%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	0.9	1.0	0.1	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	150.4	153.5	3.1	8.8%
	Medi-Cal Annual Wellness Initiative	2.4	3.8	1.4	0.1%
	Skilled Nursing Facility Access Program	9.4	10.0	0.6	0.5%
	In-Home Care Pilot Program with the UCI Family Health Center	1.3	2.0	0.7	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.7	18.0	0.3	1.0%
	Stipend Program for Master of Social Works	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.9%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Post-Pandemic Supplemental	98.6	107.5	8.9	5.7%
	Subtotal:	**$608.3**	**$820.0**	**$211.7**	**35.4%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$443.2**			**25.8%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 93 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated

[4] See HHI and HHIP summary and Allocated Funds for list of Board approved initiatives

[5] The paid amount under the Digital Transformation and Workplace Modernization has been updated for August. This figure was under reported in the July financials

Back to Agenda

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of August 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	2,489,000	5,511,000
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)*	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 39,981,060**	**$ 60,018,940**
Transfer of funds to HHIP*	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 39,981,060**	**$ 19,918,940**

Notes:

*On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

Back to Agenda

CalOptima Health

Housing and Homelessness Incentive Program
As of August 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Note:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP Incentive payments

Back to Agenda

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Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

August 31, 2023

Back to Agenda

Table of Contents

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2023

August					July - August 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
990,241	975,932	14,309	1.5%	Member Months	1,969,859	1,968,354	1,505	0.1%
362,339,929	356,484,959	5,854,970	1.6%	Revenues	725,117,707	718,596,829	6,520,878	0.9%
332,037,328	333,387,752	1,350,424	0.4%	Medical Expenses	650,999,667	669,749,885	18,750,218	2.8%
17,317,218	21,182,575	3,865,357	18.2%	Administrative Expenses	34,102,163	41,194,042	7,091,879	17.2%
12,985,383	**1,914,632**	**11,070,751**	**578.2%**	**Operating Margin**	**40,015,877**	**7,652,902**	**32,362,975**	**422.9%**
				Non-Operating Income (Loss)				
12,965,003	2,083,330	10,881,673	522.3%	Net Investment Income/Expense	27,182,774	4,166,660	23,016,114	552.4%
7,774	(32,713)	40,487	123.8%	Net Rental Income/Expense	33,334	(65,426)	98,760	150.9%
(18,558,950)	(21,003,219)	2,444,269	11.6%	Grant Expense	(19,505,920)	(22,006,439)	2,500,519	11.4%
(538,177)	-	(538,177)	(100.0%)	Other Income/Expense	(538,177)	-	(538,177)	(100.0%)
(6,124,349)	**(18,952,602)**	**12,828,253**	**67.7%**	**Total Non-Operating Income (Loss)**	**7,172,012**	**(17,905,205)**	**25,077,217**	**140.1%**
6,861,034	**(17,037,970)**	**23,899,004**	**140.3%**	**Change in Net Assets**	**47,187,889**	**(10,252,303)**	**57,440,192**	**560.3%**
91.6%	93.5%	(1.9%)		Medical Loss Ratio	89.8%	93.2%	(3.4%)	
4.8%	5.9%	1.2%		Administrative Loss Ratio	4.7%	5.7%	1.0%	
3.6%	0.5%	3.0%		Operating Margin Ratio	5.5%	1.1%	4.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima Health - Consolidated
Full Time Employee Data
For the Two Months Ended August 31, 2023

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1254	1352	99
OneCare	180	197	17
PACE	104	101	(3)
MSSP	21	24	3
Total	1559	1673	115

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	2502	2705	203
OneCare	363	394	31
PACE	207	201	(6)
MSSP	43	46	3
Total	3115	3346	231

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	775	708	(67)
OneCare	99	90	(9)
PACE	4	5	0
MSSP	24	24	(0)
Total	635	583	(52)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	773	714	(58)
OneCare	98	89	(8)
PACE	4	5	0
MSSP	23	25	1
Total	632	588	(44)

Open Positions			
	Total	Medical	Admin
Medi-Cal	83.00	28.75	54.25
OneCare	4.00	2.00	2.00
PACE	5.00	5.00	0.00
MSSP	2.00	1.00	1.00
Total	94.00	36.75	57.25

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	990,241		975,932		14,309	
REVENUE						
Medi-Cal	$ 326,963,257	$ 336.38	$ 320,868,323	$ 335.00	$ 6,094,934	$ 1.38
OneCare	32,724,643	1,836.92	31,453,665	1,782.08	1,270,978	54.84
OneCare Connect	(1,323,639)		-		(1,323,639)	-
PACE	3,762,531	8,709.56	3,909,453	8,554.60	(146,922)	154.96
MSSP	213,136	426.27	253,518	446.33	(40,382)	(20.06)
Total Operating Revenue	362,339,929	365.91	356,484,959	365.28	5,854,970	0.63
MEDICAL EXPENSES						
Medi-Cal	299,384,773	308.01	298,223,868	311.36	(1,160,905)	3.35
OneCare	31,208,360	1,751.80	31,216,481	1,768.64	8,121	16.84
OneCare Connect	(1,744,827)				1,744,827	-
PACE	2,989,318	6,919.72	3,729,734	8,161.34	740,416	1,241.62
MSSP	199,705	399.41	217,669	383.22	17,965	(16.19)
Total Medical Expenses	332,037,328	335.31	333,387,752	341.61	1,350,424	6.30
GROSS MARGIN	30,302,601	30.60	23,097,207	23.67	7,205,394	6.93
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,551,582	12.68	12,975,515	13.30	423,933	0.62
Professional Fees	481,401	0.49	1,040,695	1.07	559,294	0.58
Purchased Services	612,916	0.62	2,135,248	2.19	1,522,332	1.57
Printing & Postage	291,027	0.29	613,126	0.63	322,099	0.34
Depreciation & Amortization	916,360	0.93	400,900	0.41	(515,460)	(0.52)
Other Expenses	2,084,329	2.10	3,572,212	3.66	1,487,883	1.56
Indirect Cost Allocation, Occupancy	379,603	0.38	444,879	0.46	65,276	0.08
Total Administrative Expenses	17,317,218	17.49	21,182,575	21.70	3,865,357	4.21
INCOME (LOSS) FROM OPERATIONS	12,985,383	13.11	1,914,632	1.96	11,070,751	11.15
INVESTMENT INCOME						
Interest Income	11,842,250	11.96	2,083,330	2.13	9,758,920	9.83
Realized Gain/(Loss) on Investments	(798,056)	(0.81)	-	-	(798,056)	(0.81)
Unrealized Gain/(Loss) on Investments	1,920,809	1.94	-	-	1,920,809	1.94
Total Investment Income	12,965,003	13.09	2,083,330	2.13	10,881,673	10.96
NET RENTAL INCOME	7,774	0.01	(32,713)	(0.03)	40,487	0.04
TOTAL GRANT EXPENSE	(18,558,950)	(18.74)	(21,003,219)	(21.52)	2,444,269	2.78
OTHER INCOME/EXPENSE	(538,177)	(0.54)	-	-	(538,177)	(0.54)
CHANGE IN NET ASSETS	**6,861,034**	**6.93**	**(17,037,970)**	**(17.46)**	**23,899,004**	**24.39**
MEDICAL LOSS RATIO	**91.6%**		**93.5%**		**(1.9%)**	
ADMINISTRATIVE LOSS RATIO	**4.8%**		**5.9%**		**1.2%**	

Back to Agenda

CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	1,969,859		1,968,354		1,505	
REVENUE						
Medi-Cal	$ 655,114,824	$ 338.83	647,395,284	$ 335.06	$ 7,719,540	$ 3.77
OneCare	63,471,316	1,787.42	62,906,384	1,784.53	564,932	2.89
OneCare Connect	(1,263,173)		-		(1,263,173)	0.00
PACE	7,359,768	8,547.93	7,788,125	8,558.38	(428,357)	(10.45)
MSSP	434,973	433.67	507,036	446.33	(72,063)	(12.66)
Total Operating Revenue	725,117,707	368.11	718,596,829	365.07	6,520,878	3.04
MEDICAL EXPENSES						
Medi-Cal	586,465,544	303.32	599,748,665	310.40	13,283,121	7.08
OneCare	59,841,190	1,685.19	62,246,099	1,765.80	2,404,909	80.61
OneCare Connect	(1,747,435)				1,747,435	0.00
PACE	6,089,877	7,073.03	7,319,783	8,043.72	1,229,906	970.69
MSSP	350,490	349.44	435,338	383.22	84,848	33.78
Total Medical Expenses	650,999,667	330.48	669,749,885	340.26	18,750,218	9.78
GROSS MARGIN	74,118,041	37.63	48,846,944	24.81	25,271,097	12.82
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	23,908,288	12.14	24,884,201	12.64	975,913	0.50
Professional Fees	1,004,207	0.51	2,087,735	1.06	1,083,528	0.55
Purchased Services	2,030,518	1.03	4,170,126	2.12	2,139,608	1.09
Printing & Postage	834,617	0.42	1,226,252	0.62	391,635	0.20
Depreciation & Amortization	1,758,654	0.89	801,800	0.41	(956,854)	(0.48)
Other Expenses	3,840,441	1.95	7,134,170	3.62	3,293,729	1.67
Indirect Cost Allocation, Occupancy	725,440	0.37	889,758	0.45	164,318	0.08
Total Administrative Expenses	34,102,163	17.31	41,194,042	20.93	7,091,879	3.62
INCOME (LOSS) FROM OPERATIONS	40,015,877	20.31	7,652,902	3.89	32,362,975	16.42
INVESTMENT INCOME						
Interest Income	24,173,339	12.27	4,166,660	2.12	20,006,679	10.15
Realized Gain/(Loss) on Investments	(1,546,321)	(0.78)	-	0.00	(1,546,321)	(0.78)
Unrealized Gain/(Loss) on Investments	4,555,756	2.31	-	0.00	4,555,756	2.31
Total Investment Income	27,182,774	13.80	4,166,660	2.12	23,016,114	11.68
NET RENTAL INCOME	33,334	0.02	(65,426)	(0.03)	98,760	0.05
TOTAL GRANT EXPENSE	(19,505,920)	(9.90)	(22,006,439)	(11.18)	2,500,519	1.28
OTHER INCOME/EXPENSE	(538,177)	(0.27)	-	0.00	(538,177)	(0.27)
CHANGE IN NET ASSETS	**47,187,889**	**23.95**	**(10,252,303)**	**(5.21)**	**57,440,192**	**29.16**
MEDICAL LOSS RATIO	**89.8%**		**93.2%**		**(3.4%)**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**5.7%**		**1.0%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	606,383	365,611	971,994	17,815		432	500	990,241
REVENUES								
Capitation Revenue	191,788,544	$ 135,174,713	$ 326,963,257	$ 32,724,643	$ (1,323,639)	$ 3,762,531	$ 213,136	$ 362,339,929
Total Operating Revenue	**191,788,544**	**135,174,713**	**326,963,257**	**32,724,643**	**(1,323,639)**	**3,762,531**	**213,136**	**362,339,929**
MEDICAL EXPENSES								
Provider Capitation	61,047,815	48,584,342	109,632,157	13,237,874				122,870,031
Claims	77,161,579	48,079,711	125,241,289	7,675,884	(32,744)	1,363,667		134,248,097
MLTSS	40,140,049	5,379,122	45,519,172	82,113	(2,352)	(989)	27,361	45,625,306
Prescription Drugs	(535)		(535)	9,100,466	(1,718,141)	449,623		7,831,413
Case Mgmt & Other Medical	10,952,353	8,040,336	18,992,689	1,112,022	8,409	1,177,016	172,343	21,462,481
Total Medical Expenses	**189,301,262**	**110,083,511**	**299,384,773**	**31,208,360**	**(1,744,827)**	**2,989,318**	**199,705**	**332,037,328**
Medical Loss Ratio	*98.7%*	*81.4%*	*91.6%*	*95.4%*	*131.8%*	*79.4%*	*93.7%*	*91.6%*
GROSS MARGIN	**2,487,283**	**25,091,202**	**27,578,485**	**1,516,283**	**421,188**	**773,214**	**13,431**	**30,302,601**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			11,232,789	1,073,610	(0)	162,537	82,645	12,551,582
Non-Salary Operating Expenses			1,073,922	292,787		17,289	1,346	1,385,344
Depreciation & Amortization			915,256			1,103		916,360
Other Operating Expenses			2,025,731	38,499		13,195	6,904	2,084,329
Indirect Cost Allocation, Occupancy			(591,276)	948,600		14,749	7,530	379,603
Total Administrative Expenses			**14,656,422**	**2,353,496**	**(0)**	**208,874**	**98,426**	**17,317,218**
Administrative Loss Ratio			*4.5%*	*7.2%*	*0.0%*	*5.6%*	*46.2%*	*4.8%*
Operating Income/(Loss)			**12,922,062**	**(837,213)**	**421,189**	**564,339**	**(84,994)**	**12,985,383**
Investments and Other Non-Operating			(538,177)					(6,124,349)
CHANGE IN NET ASSETS			**$ 12,383,886**	**$ (837,213)**	**$ 421,189**	**$ 564,339**	**$ (84,994)**	**$ 6,861,034**
BUDGETED CHANGE IN NET ASSETS			4,479,239	(2,463,093)	-	(25,663)	(75,851)	(17,037,970)
Variance to Budget - Fav/(Unfav)			$ 7,904,647	$ 1,625,880	$ 421,189	$ 590,002	$ (9,143)	$ 23,899,004

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	1,208,084	725,404	1,933,488	35,510		861	1,003	1,969,859
REVENUES								
Capitation Revenue	385,530,193	$ 269,584,631	$ 655,114,824	$ 63,471,316	$ (1,263,173)	$ 7,359,768	$ 434,973	$ 725,117,707
Total Operating Revenue	**385,530,193**	**269,584,631**	**655,114,824**	**63,471,316**	**(1,263,173)**	**7,359,768**	**434,973**	**725,117,707**
MEDICAL EXPENSES								
Provider Capitation	121,915,757	98,027,534	219,943,291	25,632,094				245,575,385
Claims	144,014,564	92,730,534	236,745,098	15,059,059	(63,740)	2,959,800		254,700,217
MLTSS	79,680,141	10,410,074	90,090,215	163,904	(4,286)	(21,204)	42,336	90,270,965
Prescription Drugs	(9,025)		(9,025)	16,909,516	(1,718,348)	868,475		16,050,618
Case Mgmt & Other Medical	23,135,565	16,560,400	39,695,966	2,076,618	38,939	2,282,805	308,154	44,402,482
Total Medical Expenses	**368,737,002**	**217,728,542**	**586,465,544**	**59,841,190**	**(1,747,435)**	**6,089,877**	**350,490**	**650,999,667**
Medical Loss Ratio	*95.6%*	*80.8%*	*89.5%*	*94.3%*	*138.3%*	*82.7%*	*80.6%*	*89.8%*
GROSS MARGIN	**16,793,191**	**51,856,089**	**68,649,280**	**3,630,126**	**484,262**	**1,269,891**	**84,483**	**74,118,041**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			21,315,546	2,083,442	(0)	303,306	205,993	23,908,288
Non-Salary Operating Expenses			3,240,770	591,465	(4,253)	38,673	2,686	3,869,342
Depreciation & Amortization			1,756,464			2,189		1,758,654
Other Operating Expenses			3,715,286	97,698		20,430	7,027	3,840,441
Indirect Cost Allocation, Occupancy			(1,216,229)	1,897,200		29,409	15,060	725,440
Total Administrative Expenses			**28,811,838**	**4,669,805**	**(4,253)**	**394,008**	**230,766**	**34,102,163**
Administrative Loss Ratio			*4.4%*	*7.4%*	*0.3%*	*5.4%*	*53.1%*	*4.7%*
Operating Income/(Loss)			**39,837,442**	**(1,039,679)**	**488,515**	**875,883**	**(146,284)**	**40,015,877**
Investments and Other Non-Operating			(538,177)					7,172,012
CHANGE IN NET ASSETS			**$ 39,299,265**	**$ (1,039,679)**	**$ 488,515**	**$ 875,883**	**$ (146,284)**	**$ 47,187,889**
BUDGETED CHANGE IN NET ASSETS			12,377,559	(4,651,004)	-	70,405	(144,058)	(10,252,303)
Variance to Budget - Fav/(Unfav)			$ 26,921,706	$ 3,611,325	$ 488,515	$ 805,478	$ (2,226)	$ 57,440,192

Back to Agenda

CalOptima Health

Unaudited Financial Statements as of August 31, 2023

MONTHLY RESULTS:

- Change in Net Assets is $6.9 million, $23.9 million favorable to budget
- Operating surplus is $13.0 million, with a deficit in non-operating income of $6.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $47.2 million, $57.4 million favorable to budget
- Operating surplus is $40.0 million, with a surplus in non-operating income of $7.2 million

Change in Net Assets by Line of Business (LOB) ($ millions):

August 2023				July 2023 - August 2023		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
12.9	4.5	8.4	Medi-Cal	39.8	12.4	27.5
(0.8)	(2.5)	1.6	OneCare	(1.0)	(4.7)	3.6
0.4	0.0	0.4	OCC	0.5	0.0	0.5
0.6	(0.0)	0.6	PACE	0.9	0.1	0.8
(0.1)	(0.1)	(0.0)	MSSP	(0.1)	(0.1)	(0.0)
13.0	**1.9**	**11.1**	**Total Operating Income (Loss)**	**40.0**	**7.7**	**32.4**
			Non-Operating Income (Loss)			
13.0	2.1	10.9	Net Investment Income/Expense	27.2	4.2	23.0
0.0	(0.0)	0.0	Net Rental Income/Expense	0.0	(0.1)	0.1
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
(18.6)	(21.0)	2.4	Grant Expense	(19.5)	(22.0)	2.5
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
(0.5)	0.0	(0.5)	Other Income/(Expense)	(0.5)	0.0	(0.5)
(6.1)	**(19.0)**	**12.8**	**Total Non-Operating Income/(Loss)**	**7.2**	**(17.9)**	**25.1**
6.9	**(17.0)**	**23.9**	**TOTAL**	**47.2**	**(10.3)**	**57.4**

CalOptima Health - Consolidated
Enrollment Summary
For the Two Months Ended August 31, 2023

August					July - August 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
143,633	141,549	2,084	1.5%	SPD	286,452	284,153	2,299	0.8%
304,115	316,616	(12,501)	(3.9%)	TANF Child	606,022	635,964	(29,942)	(4.7%)
144,054	132,408	11,646	8.8%	TANF Adult	286,636	267,101	19,535	7.3%
2,992	3,118	(126)	(4.0%)	LTC	6,003	6,236	(233)	(3.7%)
365,611	352,762	12,849	3.6%	MCE	725,404	716,008	9,396	1.3%
11,589	11,372	217	1.9%	WCM	22,971	22,731	240	1.1%
971,994	**957,825**	**14,169**	**1.5%**	**Medi-Cal Total**	**1,933,488**	**1,932,193**	**1,295**	**0.1%**
17,815	**17,650**	**165**	**0.9%**	**OneCare**	**35,510**	**35,251**	**259**	**0.7%**
432	**457**	**(25)**	**(5.5%)**	**PACE**	**861**	**910**	**(49)**	**(5.4%)**
500	**568**	**(68)**	**(12.0%)**	**MSSP**	**1,003**	**1,136**	**(133)**	**(11.7%)**
990,241	**975,932**	**14,309**	**1.5%**	**CalOptima Total**	**1,969,859**	**1,968,354**	**1,505**	**0.1%**
				Enrollment (by Network)				
271,677	276,078	(4,401)	(1.6%)	HMO	541,103	556,643	(15,540)	(2.8%)
192,669	184,494	8,175	4.4%	PHC	384,344	372,195	12,149	3.3%
237,030	231,066	5,964	2.6%	Shared Risk Group	471,953	467,719	4,234	0.9%
270,618	266,187	4,431	1.7%	Fee for Service	536,088	535,636	452	0.1%
971,994	**957,825**	**14,169**	**1.5%**	**Medi-Cal Total**	**1,933,488**	**1,932,193**	**1,295**	**0.1%**
17,815	**17,650**	**165**	**0**	**OneCare**	**35,510**	**35,251**	**259**	**0**
432	**457**	**(25)**	**(5.5%)**	**PACE**	**861**	**910**	**(49)**	**(5.4%)**
500	**568**	**(68)**	**(12.0%)**	**MSSP**	**1,003**	**1,136**	**(133)**	**(11.7%)**
990,241	**975,932**	**14,309**	**1.5%**	**CalOptima Total**	**1,969,859**	**1,968,354**	**1,505**	**0.1%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287											28,554	28,291	263
TANF Child	69,607	69,928											139,535	159,351	(19,816)
TANF Adult	50,979	51,388											102,367	101,543	824
LTC		1											1		1
MCE	132,523	133,978											266,501	263,000	3,501
WCM	2,050	2,095											4,145	4,458	(313)
Total	**269,426**	**271,677**											**541,103**	**556,643**	**(15,540)**
PHCs															
SPD	4,581	4,599											9,180	8,866	314
TANF Child	147,946	148,557											296,503	296,908	(405)
TANF Adult	8,999	9,050											18,049	6,868	11,181
LTC													-		0
MCE	23,230	23,489											46,719	45,936	783
WCM	6,919	6,974											13,893	13,617	276
Total	**191,675**	**192,669**											**384,344**	**372,195**	**12,149**
Shared Risk Groups															
SPD	11,210	11,137											22,347	22,628	(281)
TANF Child	55,211	55,471											110,682	117,339	(6,657)
TANF Adult	43,118	43,425											86,543	79,980	6,563
LTC	1	1											2		2
MCE	124,149	125,749											249,898	245,271	4,627
WCM	1,234	1,247											2,481	2,501	(20)
Total	**234,923**	**237,030**											**471,953**	**467,719**	**4,234**
Fee for Service (Dual)															
SPD	99,242	99,832											199,074	197,835	1,239
TANF Child													-	4	(4)
TANF Adult	2,442	2,397											4,839	4,817	22
LTC	2,661	2,630											5,291	5,496	(205)
MCE	8,968	9,230											18,198	18,844	(646)
WCM	15	14											29	36	(7)
Total	**113,328**	**114,103**											**227,431**	**227,032**	**399**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778											27,297	26,533	764
TANF Child	29,143	30,159											59,302	62,362	(3,060)
TANF Adult	37,044	37,794											74,838	73,893	945
LTC	349	360											709	740	(31)
MCE	70,923	73,165											144,088	142,957	1,131
WCM	1,164	1,259											2,423	2,119	304
Total	**152,142**	**156,515**											**308,657**	**308,604**	**53**
Grand Totals															
SPD	142,819	143,633											286,452	284,153	2,299
TANF Child	301,907	304,115											606,022	635,964	(29,942)
TANF Adult	142,582	144,054											286,636	267,101	19,535
LTC	3,011	2,992											6,003	6,236	(233)
MCE	359,793	365,611											725,404	716,008	9,396
WCM	11,382	11,589											22,971	22,731	240
Total MediCal MM	**961,494**	**971,994**											**1,933,488**	**1,932,193**	**1,295**
OneCare	**17,695**	**17,815**											**35,510**	**35,251**	**259**
PACE	**429**	**432**											**861**	**910**	**(49)**
MSSP	**503**	**500**											**1,003**	**1,136**	**(133)**
Grand Total	**979,618**	**990,241**											**1,969,859**	**1,968,354**	**1,505**

Note:* Total membership does not include MSSP

Back to Agenda

ENROLLMENT:

Overall, August enrollment was 990,241

- Favorable to budget 14,309 or 1.5%
- Increased 10,623 or 1.1% from Prior Month (PM) (July 2023)
- Increased 64,485 or 7.0% from Prior Year (PY) (August 2022)

Medi-Cal enrollment was 971,994

- Favorable to budget 14,169 or 1.5%
  - Medi-Cal Expansion (MCE) favorable 12,849 due to a delay in disenrollment caused by a statewide system issue with the Department of Health Care Servies (DHCS)
  - Seniors and Persons with Disabilities (SPD) favorable 2,084
  - Whole Child Model (WCM) favorable 217
  - Temporary Assistance for Needy Families (TANF) unfavorable 855
  - Long-Term Care (LTC) unfavorable 126
- Increased 10,500 from PM

OneCare enrollment was 17,815

- Favorable to budget 165 or 0.9%
- Increased 120 from PM

PACE enrollment was 432

- Unfavorable to budget 25 or 5.5%
- Increased 3 from PM

MSSP enrollment was 500

- Unfavorable to budget 68 or 12.0%
- Decreased 3 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
971,994	**957,825**	**14,169**	**1.5%**	**Member Months**	**1,933,488**	**1,932,193**	**1,295**	**0.1%**
				Revenues				
326,963,257	320,868,323	6,094,934	1.9%	Medi-Cal Capitation Revenue	655,114,824	647,395,284	7,719,540	1.2%
326,963,257	**320,868,323**	**6,094,934**	**1.9%**	**Total Operating Revenue**	**655,114,824**	**647,395,284**	**7,719,540**	**1.2%**
				Medical Expenses				
109,632,157	107,532,431	(2,099,726)	(2.0%)	Provider Capitation	219,943,291	217,200,061	(2,743,230)	(1.3%)
74,765,958	75,709,488	943,530	1.2%	Facilities Claims	138,224,137	152,225,516	14,001,379	9.2%
50,475,331	47,072,437	(3,402,894)	(7.2%)	Professional Claims	98,520,961	94,688,317	(3,832,644)	(4.0%)
45,519,172	51,865,183	6,346,011	12.2%	MLTSS	90,090,215	103,910,819	13,820,604	13.3%
(535)	-	535	100.0%	Prescription Drugs	(9,025)	-	9,025	100.0%
12,015,109	7,241,431	(4,773,678)	(65.9%)	Incentive Payments	26,288,684	14,626,453	(11,662,231)	(79.7%)
6,121,376	7,786,857	1,665,481	21.4%	Medical Management	11,719,998	15,065,865	3,345,867	22.2%
856,204	1,016,041	159,837	15.7%	Other Medical Expenses	1,687,283	2,031,634	344,351	16.9%
299,384,773	**298,223,868**	**(1,160,905)**	**(0.4%)**	**Total Medical Expenses**	**586,465,544**	**599,748,665**	**13,283,121**	**2.2%**
27,578,485	**22,644,455**	**4,934,030**	**21.8%**	**Gross Margin**	**68,649,280**	**47,646,619**	**21,002,661**	**44.1%**
				Administrative Expenses				
11,232,789	11,509,663	276,874	2.4%	Salaries, Wages & Employee Benefits	21,315,546	22,062,233	746,687	3.4%
432,889	959,458	526,569	54.9%	Professional Fees	904,934	1,925,261	1,020,327	53.0%
407,780	1,861,016	1,453,236	78.1%	Purchased Services	1,660,446	3,621,662	1,961,216	54.2%
233,253	483,310	250,057	51.7%	Printing & Postage	675,391	966,620	291,229	30.1%
915,256	400,000	(515,256)	(128.8%)	Depreciation & Amortization	1,756,464	800,000	(956,464)	(119.6%)
2,025,731	3,477,860	1,452,129	41.8%	Other Operating Expenses	3,715,286	6,945,466	3,230,180	46.5%
(591,276)	(526,091)	65,185	12.4%	Indirect Cost Allocation, Occupancy	(1,216,229)	(1,052,182)	164,047	15.6%
14,656,422	**18,165,216**	**3,508,794**	**19.3%**	**Total Administrative Expenses**	**28,811,838**	**35,269,060**	**6,457,222**	**18.3%**
				Non-Operating Income (Loss)				
(538,177)	-	(538,177)	(100.0%)	Other Income/Expense	(538,177)	-	(538,177)	(100.0%)
(538,177)	**-**	**(538,177)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(538,177)**	**-**	**(538,177)**	**(100.0%)**
12,383,886	**4,479,239**	**7,904,647**	**176.5%**	**Change in Net Assets**	**39,299,265**	**12,377,559**	**26,921,706**	**217.5%**
91.6%	***92.9%***	***(1.4%)***		***Medical Loss Ratio***	***89.5%***	***92.6%***	***(3.1%)***	
4.5%	***5.7%***	***1.2%***		***Admin Loss Ratio***	***4.4%***	***5.4%***	***1.0%***	

Back to Agenda

MEDI-CAL INCOME STATEMENT– AUGUST MONTH:

REVENUES of $327.0 million are favorable to budget $6.1 million driven by:

- Favorable volume related variance of $4.7 million
- Favorable price related variance of $1.3 million
  - $3.3 million due to Student Behavioral Health Incentive Program (SBHIP)
  - $2.2 million from favorable enrollment mix
  - $0.6 million of prior month revenue due to retroactivity
  - Offset by:
    - $4.8 million from Proposition 56 and Enhanced Care Management (ECM) risk corridor

MEDICAL EXPENSES of $299.4 million are unfavorable to budget $1.2 million driven by:

- Unfavorable volume related variance of $4.4 million
- Favorable price related variance of $3.3 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $7.1 million due to lower than budgeted utilization
  - Facilities Claims expense favorable variance of $2.1 million
  - Medical Management expense favorable variance of $1.8 million
  - Offset by:
    - Incentive Payments expense unfavorable variance of $4.7 million due primarily to SBHIP
    - Professional Claims expense unfavorable variance of $2.7 million
    - Provider Capitation expense unfavorable variance of $0.5 million

ADMINISTRATIVE EXPENSES of $14.7 million are favorable to budget $3.5 million driven by:

- Non-Salary expenses favorable to budget $3.2 million due to Claims department recovery vendors, advertising, and Information Technology
- Salaries & Benefit expense favorable to budget $0.3 million

CHANGE IN NET ASSETS is $12.4 million, favorable to budget $7.9 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,815	**17,650**	**165**	**0.9%**	**Member Months**	**35,510**	**35,251**	**259**	**0.7%**
				Revenues				
23,585,449	22,760,145	825,304	3.6%	Medicare Part C Revenue	46,091,017	45,540,330	550,687	1.2%
9,139,194	8,693,520	445,674	5.1%	Medicare Part D Revenue	17,380,299	17,366,054	14,245	0.1%
32,724,643	**31,453,665**	**1,270,978**	**4.0%**	**Total Operating Revenue**	**63,471,316**	**62,906,384**	**564,932**	**0.9%**
				Medical Expenses				
13,237,874	13,037,080	(200,794)	(1.5%)	Provider Capitation	25,632,094	26,085,934	453,840	1.7%
6,062,864	5,196,083	(866,781)	(16.7%)	Inpatient	12,134,099	10,364,442	(1,769,657)	(17.1%)
1,613,020	1,467,564	(145,456)	(9.9%)	Ancillary	2,924,960	2,928,599	3,639	0.1%
82,113	81,370	(743)	(0.9%)	MLTSS	163,904	162,512	(1,392)	(0.9%)
9,100,466	9,748,136	647,670	6.6%	Prescription Drugs	16,909,516	19,415,816	2,506,300	12.9%
35,291	384,338	349,047	90.8%	Incentive Payments	84,235	777,614	693,379	89.2%
1,076,731	1,301,910	225,179	17.3%	Medical Management	1,992,383	2,511,182	518,799	20.7%
31,208,360	**31,216,481**	**8,121**	**0.0%**	**Total Medical Expenses**	**59,841,190**	**62,246,099**	**2,404,909**	**3.9%**
1,516,283	**237,184**	**1,279,099**	**539.3%**	**Gross Margin**	**3,630,126**	**660,285**	**2,969,841**	**449.8%**
				Administrative Expenses				
1,073,610	1,207,178	133,568	11.1%	Salaries, Wages & Employee Benefits	2,083,442	2,325,091	241,649	10.4%
46,462	75,000	28,538	38.1%	Professional Fees	94,903	150,000	55,097	36.7%
188,550	265,942	77,392	29.1%	Purchased Services	337,337	531,884	194,547	36.6%
57,774	125,704	67,930	54.0%	Printing & Postage	159,226	251,408	92,182	36.7%
38,499	77,870	39,371	50.6%	Other Operating Expenses	97,698	155,740	58,042	37.3%
948,600	948,583	(17)	(0.0%)	Indirect Cost Allocation, Occupancy	1,897,200	1,897,166	(34)	(0.0%)
2,353,496	**2,700,277**	**346,781**	**12.8%**	**Total Administrative Expenses**	**4,669,805**	**5,311,289**	**641,484**	**12.1%**
(837,213)	**(2,463,093)**	**1,625,880**	**66.0%**	**Change in Net Assets**	**(1,039,679)**	**(4,651,004)**	**3,611,325**	**77.6%**
95.4%	***99.2%***	***(3.9%)***		***Medical Loss Ratio***	***94.3%***	***99.0%***	***(4.7%)***	
7.2%	***8.6%***	***1.4%***		***Admin Loss Ratio***	***7.4%***	***8.4%***	***1.1%***	

Back to Agenda

ONECARE INCOME STATEMENT– AUGUST MONTH:

REVENUES of $32.7 million are favorable to budget $1.3 million driven by:

- Favorable volume related variance of $0.3 million
- Favorable price related variance of $1.0 million

MEDICAL EXPENSES of $31.2 million are favorable to budget $8,121 driven by:

- Unfavorable volume related variance of $0.3 million
- Favorable price related variance of $0.3 million

ADMINISTRATIVE EXPENSES of $2.4 million are favorable to budget $0.3 million driven by:

- Non-Salary expenses favorable to budget $0.2 million
- Salaries & Benefit expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.8) million, favorable to budget $1.6 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
26,919	-	26,919	100.0%	Medi-Cal Revenue	33,563	-	33,563	100.0%
(1,350,558)	-	(1,350,558)	(100.0%)	Medicare Part D Revenue	(1,296,736)	-	(1,296,736)	(100.0%)
(1,323,639)	**-**	**(1,323,639)**	**(100.0%)**	**Total Operating Revenue**	**(1,263,173)**	**-**	**(1,263,173)**	**(100.0%)**
				Medical Expenses				
(104,305)	-	104,305	100.0%	Facilities Claims	(211,397)	-	211,397	100.0%
71,560	-	(71,560)	(100.0%)	Ancillary	147,658	-	(147,658)	(100.0%)
(2,352)	-	2,352	100.0%	MLTSS	(4,286)	-	4,286	100.0%
(1,718,141)	-	1,718,141	100.0%	Prescription Drugs	(1,718,348)	-	1,718,348	100.0%
8,409	-	(8,409)	(100.0%)	Incentive Payments	38,939	-	(38,939)	(100.0%)
(1,744,827)	**-**	**1,744,827**	**100.0%**	**Total Medical Expenses**	**(1,747,435)**	**-**	**1,747,435**	**100.0%**
421,188	**-**	**421,188**	**100.0%**	**Gross Margin**	**484,262**	**-**	**484,262**	**100.0%**
				Administrative Expenses				
(0)	-	0	100.0%	Salaries, Wages & Employee Benefits	(0)	-	0	100.0%
-	-	-	0.0%	Purchased Services	(4,253)	-	4,253	100.0%
-	-	-	0.0%	Printing & Postage	0	-	(0)	(100.0%)
(0)	**-**	**0**	**100.0%**	**Total Administrative Expenses**	**(4,253)**	**-**	**4,253**	**100.0%**
421,189	**-**	**421,189**	**100.0%**	**Change in Net Assets**	**488,515**	**-**	**488,515**	**100.0%**
131.8%	***0.0%***	***131.8%***		***Medical Loss Ratio***	***138.3%***	***0.0%***	***138.3%***	
0.0%	***0.0%***	***(0.0%)***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

Back to Agenda

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
432	**457**	(25)	(5.5%)	**Member Months**	**861**	**910**	**(49)**	**(5.4%)**
				Revenues				
2,807,948	2,964,617	(156,669)	(5.3%)	Medi-Cal Capitation Revenue	5,603,204	5,902,946	(299,742)	(5.1%)
675,003	735,687	(60,684)	(8.2%)	Medicare Part C Revenue	1,233,785	1,469,130	(235,345)	(16.0%)
279,581	209,149	70,432	33.7%	Medicare Part D Revenue	522,779	416,049	106,730	25.7%
3,762,531	**3,909,453**	**(146,922)**	**(3.8%)**	**Total Operating Revenue**	**7,359,768**	**7,788,125**	**(428,357)**	**(5.5%)**
				Medical Expenses				
1,177,016	1,197,914	20,898	1.7%	Medical Management	2,282,805	2,320,742	37,937	1.6%
401,291	895,414	494,123	55.2%	Facilities Claims	1,180,081	1,780,662	600,581	33.7%
746,212	877,871	131,659	15.0%	Professional Claims	1,354,807	1,712,895	358,088	20.9%
449,623	452,495	2,872	0.6%	Prescription Drugs	868,475	897,386	28,911	3.2%
(989)	118,552	119,541	100.8%	MLTSS	(21,204)	236,586	257,790	109.0%
216,164	187,488	(28,676)	(15.3%)	Patient Transportation	424,912	371,512	(53,400)	(14.4%)
2,989,318	**3,729,734**	**740,416**	**19.9%**	**Total Medical Expenses**	**6,089,877**	**7,319,783**	**1,229,906**	**16.8%**
773,214	**179,719**	**593,495**	**330.2%**	**Gross Margin**	**1,269,891**	**468,342**	**801,549**	**171.1%**
				Administrative Expenses				
162,537	163,275	738	0.5%	Salaries, Wages & Employee Benefits	303,306	313,723	10,417	3.3%
716	4,904	4,188	85.4%	Professional Fees	1,704	9,808	8,104	82.6%
16,573	8,290	(8,283)	(99.9%)	Purchased Services	36,969	16,580	(20,389)	(123.0%)
-	4,112	4,112	100.0%	Printing & Postage	-	8,224	8,224	100.0%
1,103	900	(203)	(22.6%)	Depreciation & Amortization	2,189	1,800	(389)	(21.6%)
13,195	9,039	(4,156)	(46.0%)	Other Operating Expenses	20,430	18,078	(2,352)	(13.0%)
14,749	14,862	113	0.8%	Indirect Cost Allocation, Occupancy	29,409	29,724	315	1.1%
208,874	**205,382**	**(3,492)**	**(1.7%)**	**Total Administrative Expenses**	**394,008**	**397,937**	**3,929**	**1.0%**
564,339	**(25,663)**	**590,002**	**2299.0%**	**Change in Net Assets**	**875,883**	**70,405**	**805,478**	**1144.1%**
79.4%	***95.4%***	***(16.0%)***		***Medical Loss Ratio***	***82.7%***	***94.0%***	***(11.2%)***	
5.6%	***5.3%***	***(0.3%)***		***Admin Loss Ratio***	***5.4%***	***5.1%***	***(0.2%)***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
500	**568**	**(68)**	**(12.0%)**	**Member Months**	**1,003**	**1,136**	**(133)**	**(11.7%)**
				Revenues				
213,136	253,518	(40,382)	(15.9%)	Revenue	434,973	507,036	(72,063)	(14.2%)
213,136	**253,518**	**(40,382)**	**(15.9%)**	**Total Operating Revenue**	**434,973**	**507,036**	**(72,063)**	**(14.2%)**
				Medical Expenses				
172,343	184,712	12,369	6.7%	Medical Management	308,154	369,424	61,270	16.6%
27,361	32,957	5,596	17.0%	Waiver Services	42,336	65,914	23,578	35.8%
172,343	184,712	12,369	6.7%	Total Medical Management	308,154	369,424	61,270	16.6%
27,361	32,957	5,596	17.0%	Total Waiver Services	42,336	65,914	23,578	35.8%
199,705	**217,669**	**17,965**	**8.3%**	**Total Program Expenses**	**350,490**	**435,338**	**84,848**	**19.5%**
13,431	**35,849**	**(22,418)**	**(62.5%)**	**Gross Margin**	**84,483**	**71,698**	**12,785**	**17.8%**
				Administrative Expenses				
82,645	95,399	12,754	13.4%	Salaries, Wages & Employee Benefits	205,993	183,154	(22,839)	(12.5%)
1,333	1,333	(0)	(0.0%)	Professional Fees	2,667	2,666	(1)	(0.0%)
13	-	(13)	(100.0%)	Purchased Services	20	-	(20)	(100.0%)
6,904	7,443	539	7.2%	Other Operating Expenses	7,027	14,886	7,859	52.8%
7,530	7,525	(5)	(0.1%)	Indirect Cost Allocation, Occupancy	15,060	15,050	(10)	(0.1%)
98,426	**111,700**	**13,274**	**11.9%**	**Total Administrative Expenses**	**230,766**	**215,756**	**(15,010)**	**(7.0%)**
(84,994)	**(75,851)**	**(9,143)**	**(12.1%)**	**Change in Net Assets**	**(146,284)**	**(144,058)**	**(2,226)**	**(1.5%)**
93.7%	***85.9%***	***7.8%***		***Medical Loss Ratio***	***80.6%***	***85.9%***	***(5.3%)***	
46.2%	***44.1%***	***(2.1%)***		***Admin Loss Ratio***	***53.1%***	***42.6%***	***(10.5%)***	

Back to Agenda

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
48,927	21,873	(27,054)	(123.7%)	Purchased Services	92,332	43,746	(48,586)	(111.1%)
177,480	211,000	33,520	15.9%	Depreciation & Amortization	354,960	422,000	67,040	15.9%
22,758	34,000	11,242	33.1%	Insurance Expense	45,517	68,000	22,483	33.1%
101,326	167,302	65,976	39.4%	Repair & Maintenance	215,910	334,604	118,694	35.5%
98,865	57,859	(41,006)	(70.9%)	Other Operating Expenses	150,579	115,718	(34,861)	(30.1%)
(449,356)	(492,034)	(42,678)	(8.7%)	Indirect Cost Allocation, Occupancy	(859,298)	(984,068)	(124,770)	(12.7%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

Back to Agenda

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
155,930	133,810	22,120	16.5%	Rental Income	318,415	267,620	50,795	19.0%
155,930	**133,810**	**22,120**	**16.5%**	**Total Operating Revenue**	**318,415**	**267,620**	**50,795**	**19.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
18,878	7,126	(11,752)	(164.9%)	Purchased Services	32,241	14,252	(17,989)	(126.2%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	69,146	80,000	10,854	13.6%
7,500	10,091	2,591	25.7%	Insurance Expense	15,001	20,182	5,181	25.7%
43,250	84,860	41,610	49.0%	Repair & Maintenance	80,717	169,720	89,003	52.4%
43,954	24,446	(19,508)	(79.8%)	Other Operating Expenses	87,976	48,892	(39,084)	(79.9%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
148,156	**166,523**	**18,367**	**11.0%**	**Total Administrative Expenses**	**285,081**	**333,046**	**47,966**	**14.4%**
7,774	**(32,713)**	**40,487**	**123.8%**	**Change in Net Assets**	**33,334**	**(65,426)**	**98,760**	**150.9%**

Back to Agenda

OTHER INCOME STATEMENTS – AUGUST MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.4 million due to prior year activities

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million favorable to budget $0.6 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($84,994), unfavorable to budget $9,143

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $7,774, favorable to budget $40,487

- Net of $0.2 million in rental income and $0.1 million in expenses

INVESTMENT INCOME

- Favorable variance of $10.9 million due to $9.8 million of interest income and by $1.1 million realized and unrealized net gain on investments

GRANT EXPENSE AND OTHER INCOME/(EXPENSE)

- Favorable variance of $1.9 million due mainly to $2.5 million for the Naloxone grant, offset by a $0.5 million deposit loss for the Tustin building purchase

CalOptima Health
Balance Sheet
August 31, 2023

	August-23	July-23	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	696,603,705	551,847,227	144,756,478	26.2%
Short-term Investments	1,826,657,374	1,941,670,466	(115,013,093)	(5.9%)
Premiums due from State of CA and CMS	423,739,500	457,618,445	(33,878,945)	(7.4%)
Prepaid Expenses and Other	16,462,216	16,004,428	457,788	2.9%
Total Current Assets	**2,963,462,795**	**2,967,140,566**	**(3,677,771)**	**(0.1%)**
Board Designated Assets				
Cash and Cash Equivalents	1,470,984	(1,528,168)	2,999,152	196.3%
Investments	579,544,984	580,522,032	(977,047)	(0.2%)
Total Board Designated Assets	**581,015,968**	**578,993,864**	**2,022,104**	**0.3%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	84,644,423	83,945,137	699,286	0.8%
Total Assets	3,629,423,186	3,630,379,567	(956,381)	(0.0%)
Deferred Outflows of Resources				
Net Pension	24,373,350	24,373,350	-	0.0%
Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
Total Deferred Outflows of Resources	**25,969,350**	**25,969,350**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**3,655,392,536**	**3,656,348,917**	**(956,381)**	**(0.0%)**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,646,406,865	1,654,203,326	(7,796,461)	(0.5%)
Provider Capitation and Withholds	134,171,890	129,515,347	4,656,542	3.6%
Accrued Reinsurance Costs to Providers	5,645,424	4,978,758	666,666	13.4%
Unearned Revenue	33,028,713	36,931,649	(3,902,936)	(10.6%)
Accounts Payable and Other	13,950,826	15,219,697	(1,268,870)	(8.3%)
Accrued Payroll and Employee Benefits and Other	19,721,186	18,347,184	1,374,002	7.5%
Deferred Lease Obligations	48,992	52,156	(3,164)	(6.1%)
Total Current Liabilities	**1,852,973,897**	**1,859,248,117**	**(6,274,221)**	**(0.3%)**
GASB 96 Subscription Liabilities	14,520,742	16,107,717	(1,586,975)	(9.9%)
Postemployment Health Care Plan	19,063,095	19,019,314	43,781	0.2%
Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities	**1,927,022,878**	**1,934,840,293**	**(7,817,415)**	**(0.4%)**
Deferred Inflows of Resources				
Net Pension	3,387,516	3,387,516	-	0.0%
Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position				
Required TNE	108,217,951	108,222,485	(4,534)	(0.0%)
Funds in excess of TNE	1,608,976,192	1,602,110,624	6,865,568	0.4%
Total Net Position	**1,717,194,142**	**1,710,333,109**	**6,861,034**	**0.4%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**3,655,392,536**	**3,656,348,917**	**(956,381)**	**(0.0%)**

Back to Agenda

BALANCE SHEET – AUGUST MONTH:

ASSETS of $3.7 billion decreased $1.0 million from July or 0.0%

- Capitation Receivables decreased $32.7 million due to timing of cash receipt
- Operating Cash and Short-term Investments net increase of $29.7 million due to the timing of Centers for Medicare & Medicaid Services (CMS) payments

LIABILITIES of $1.9 billion decreased $7.8 million from July or 0.4%

- Medical Claims Liabilities decreased $7.1 million due to timing of claim payments
- Deferred Revenue decreased $3.9 million due to SBHIP
- Capitation and Withholds increased $4.7 million due to timing of capitation payments

NET ASSETS of $1.7 billion, increased $6.9 million from July or 0.4%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of August 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	236,895,290				
	Tier 1 - MetLife	235,039,626				
Board Designated Reserve		471,934,916	349,766,729	546,045,878	122,168,187	(74,110,962)
	Tier 2 - Payden & Rygel	54,679,671				
	Tier 2 - MetLife	54,401,381				
TNE Requirement		109,081,053	108,217,951	108,217,951	863,102	863,102
	Consolidated:	**581,015,968**	**457,984,680**	**654,263,829**	**123,031,288**	**(73,247,860)**
	Current reserve level	*1.78*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health
Statement of Cash Flows
August 31, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	6,861,034	47,187,889
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,128,413	2,182,760
Changes in assets and liabilities:		
Prepaid expenses and other	(457,788)	(1,401,514)
Catastrophic reserves		
Capitation receivable	33,878,945	50,184,198
Medical claims liability	(7,129,795)	11,813,525
Deferred revenue	(3,902,936)	(30,414,199)
Payable to health networks	4,656,542	8,727,864
Accounts payable	(1,268,870)	(1,131,117)
Accrued payroll	1,417,783	(3,523,110)
Other accrued liabilities	(1,590,139)	(1,593,291)
Net cash provided by/(used in) operating activities	33,593,188	82,033,007
GASB 68 and GASB 75 Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	115,013,093	(149,921,310)
Change in Property and Equipment	(1,827,698)	(2,619,678)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(2,022,104)	(4,464,275)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	111,163,290	(157,005,263)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	144,756,478	(74,972,256)
CASH AND CASH EQUIVALENTS, beginning of period	$551,847,227	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**696,603,705**	**696,603,706**

CalOptima Health - Consolidated
Net Assets Analysis
For the One Month Ended August 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 8/31/2023	**$1,717.2**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**581.0**			**33.8%**
	Capital Assets, net of Depreciation[2]	**84.6**			**4.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$19.9	$59.9	$40.0	1.2%
	Housing and Homelessness Initiative Program[4]	69.7	97.2	27.5	4.1%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.4%
	Digital Transformation and Workplace Modernization[5]	71.3	100.0	28.7	4.2%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.8	8.0	1.2	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.3%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	0.9	1.0	0.1	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	150.4	153.5	3.1	8.8%
	Medi-Cal Annual Wellness Initiative	2.4	3.8	1.4	0.1%
	Skilled Nursing Facility Access Program	9.4	10.0	0.6	0.5%
	In-Home Care Pilot Program with the UCI Family Health Center	1.3	2.0	0.7	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.7	18.0	0.3	1.0%
	Stipend Program for Master of Social Works	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.9%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Post-Pandemic Supplemental	98.6	107.5	8.9	5.7%
	Subtotal:	**$608.3**	**$820.0**	**$211.7**	**35.4%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$443.2**			**25.8%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 93 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated

[4] See HHI and HHIP summary and Allocated Funds for list of Board approved initiatives

[5] The paid amount under the Digital Transformation and Workplace Modernization has been updated for August. This figure was under reported in the July financials

Back to Agenda

CalOptima Health
Key Financial Indicators
As of August 31, 2023

Income Statement

Item Name	Month-to-Date (Aug 2023) Actual	Budget	Variance	%		FY 2024 Year-to-Date (Aug 2023) Actual	Budget	Variance	%	
Member Months	990,241	975,932	14,309	1.5%		1,969,859	1,968,354	1,505	0.1%	
*Operating Revenue **	362,339,929	356,484,959	5,854,970	1.6%		725,117,707	718,596,829	6,520,878	0.9%	
*Medical Expenses **	332,037,328	333,387,752	1,350,424	0.4%		650,999,667	669,749,885	18,750,218	2.8%	
General and Administrative Expense	17,317,218	21,182,575	3,865,357	18.2%		34,102,163	41,194,042	7,091,879	17.2%	
Non-Operating Income/(Loss)	(6,124,349)	(18,952,602)	12,828,253	67.7%		7,172,012	(17,905,205)	25,077,217	140.1%	
Summary of Income & Expenses	6,861,034	(17,037,970)	23,899,004	140.3%		47,187,889	(10,252,303)	57,440,192	560.3%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	91.6%	93.5%	(1.9%)		89.8%	93.2%	(3.4%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.8%	5.9%	1.2%		4.7%	5.7%	1.0%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@8/31/2023	2,387,443,347	2,506,471,438	(119,028,091)	(4.7%)

Unallocated/Unassigned Reserve Balance	Current Month @August 2023	Fiscal Year Ending June 2023	Change	%
Consolidated	443,242,887	354,771,258	88,471,628	24.9%
*Days Cash On Hand***	93			

**Total of Board Designated Reserve and unallocated reserve amount can support approximatley 93 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Two Months Ending August 31, 2023

	FY 2024 Month-to-Date				FY 2024 Year-to-Date				Life to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**16,261,078**	**4,819,310**	**(11,441,768)**	**(237.4%)**	**16,388,174**	**9,638,620**	**(6,749,554)**	**(70.0%)**	**19,986,225**	**46,484,620**	**26,498,395**	**57.0%**
Operating Expenses:												
Salaries, Wages & Benefits	634,395	609,649	(24,746)	(4.1%)	1,218,850	1,219,298	448	0.0%	4,637,426	6,511,531	1,874,105	28.8%
Professional Fees	21,286	175,416	154,130	87.9%	30,998	350,832	319,834	91.2%	297,191	2,483,332	2,186,141	88.0%
Purchased Services	-	155,000	155,000	100.0%	-	310,000	310,000	100.0%	-	620,000	620,000	100.0%
Depreciation Expenses												
Other Expenses	249,576	1,278,509	1,028,933	80.5%	798,628	2,557,018	1,758,390	68.8%	3,813,404	5,949,398	2,135,994	35.9%
Total Operating Expenses	**905,257**	**2,218,574**	**1,313,317**	59.2%	**2,048,475**	**4,437,148**	**2,388,673**	**53.8%**	**8,748,021**	**15,564,261**	**6,816,240**	**43.8%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2023	10,297,597	47,973,113
FY2024	18,436,649	47,609,899
FY2025		
Ending Funding Balance	**71,265,754**	**4,416,988**

Back to Agenda

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of August 31, 2023

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	2,489,000	5,511,000
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 39,981,061**	**$ 60,018,939**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 39,981,061**	**$ 19,918,939**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of August 31, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

Back to Agenda

CalOptima Health
Budget Allocation Changes
Reporting Changes for August 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services. ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-2024
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP.	2023-2024
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter.	2023-2024
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce Inview to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract.	2023-2024
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training.	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation.	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards.	2023-24

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

Board of Directors Meeting
October 5, 2023

Monthly Compliance Report

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

A. Updates on Regulatory Audits

2023 OneCare Compliance Program Effectiveness (CPE) Audit

Update:

- CalOptima Health has contracted with an independent consulting group to conduct a CPE audit of CalOptima Health.
- The audit has commenced, and CalOptima Health is currently finalizing updates to the supplemental documentation and has requested the business areas to submit universes which are due to consulting group on September 22, 2023.

Background:

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis.

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

Update:

As of August 31, 2023:

- **218 deliverables have been submitted** for 2024 MCP operational readiness.
- **194 items have received approval** at this point.
  - Remaining deliverables are awaiting a response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.
  - On 9/5/23, CalOptima Health received approval from the Department of Health Care Services (DHCS) for go – live implementation of the new DHCS contract effective January 1, 2024.
  - DHCS' approval is contingent on full completion of all Operational Readiness 2024 deliverables.
  - CalOptima Health is on-track for all remaining deliverables.

Back to Agenda

Please be advised that a final version of the 2024 MCP Contract has not yet been provided to CalOptima Health.

Background – FYI Only
Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health are required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by January 1, 2024, contract effective date.

- **2023 DHCS Routine Medical Audit:**

Update: On 8/18/23, DHCS provided CalOptima Health with the final Medical Audit reports and formal request for corrective action. The final reports reflect the results:
- 2023 Medical Audit Report: 2 findings
- 2023 State Supported Services Report: No findings
- 2023 Cal MediConnect Audit Report: No findings
- The 2 findings included in the main 2023 Medical Audit Report remain unchanged from the draft report.
- The final report includes a revision to the report narrative, at CalOptima Health's request.
- DHCS has requested a response to its corrective action request by 9/17/23.
- CalOptima Health has prepared its response to DHCS' request for corrective action and is on-track for a timely submission.

Background – FYI Only
On 7/5/23, CalOptima Health received the draft findings report for the 2023 DHCS Medical Audit. DHCS' draft findings report identified **two (2) findings**; this is an improvement from the 2022 DHCS Medical Audit which resulted in nine (9) total findings.

Below is a summary of the draft findings and identified next steps:
- Category breakdown and findings are as follows:
  - Category 1 Utilization Management (UM) – **No Findings**
  - Category 2 Case Management and Coordination of Care – **2 Findings**
  - Category 3 Access and Availability of Care – **No Findings**
  - Category 4 Members' Rights – **No Findings**
  - Category 5 Quality Management – **No Findings**
  - Category 6 Administrative and Organizational Capacity – **No Findings**

The summary of the draft findings in Category 2 are as follows:
- **2.1.1 Provision of Initial Health Assessment (IHA)**
  DHCS Finding #1: The Plan did not ensure that an IHA was performed by the member's primary care providers, perinatal care providers, and non-physician mid-level practitioners.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.
- **2.2.1 - Performance of Pediatric Risk Stratification Process (PRSP)**

Back to Agenda

DHCS Finding #2: The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.

- DHCS Recommendation: Revise and implement policies and procedures to ensure compliance with PRSP performance to WCM members.

Annual (routine) Audit Scope:

- Utilization management
- Case management and coordination of care
- Availability and accessibility
- Member rights
- Quality management
- Administrative and organizational capacity

Focused Audit:

- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023.
- No soft exit.
- Once DHCS concludes its focused audit reviews of all MCPs, a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of August 2023.

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits:**

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

    - CHOC Health Alliance, July 1, 2022 to April 30, 2023

  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Internal Audit Updates

- Internal Audit of Medi-Cal Customer Service (CS)

  - During the second quarter of 2023, CalOptima Health's Audit & Oversight department conducted internal audits on the following internal departments to assess to ensure compliance with universe, timeliness, clinical decision-making, and processing requirements, as applicable for the review period of January 1, 2023 to April 30, 2023:
    - Customer Service (Medi-Cal)
    - Grievance and Appeals (OneCare)

  - For areas that scored below the 96% threshold, A&O issued a corrective action plan (CAP) request and is actively working with the department to remediate findings.
    - **Customer Service (Medi-Cal):** There were a total of six (6) audit areas within this audit.
      - Two (2) CAPs have been issued to the department.
    - **Grievance and Appeals (OneCare):** There were a total of nineteen (19) audit areas within this audit.
      - Five (5) CAPs have been issued to the department.

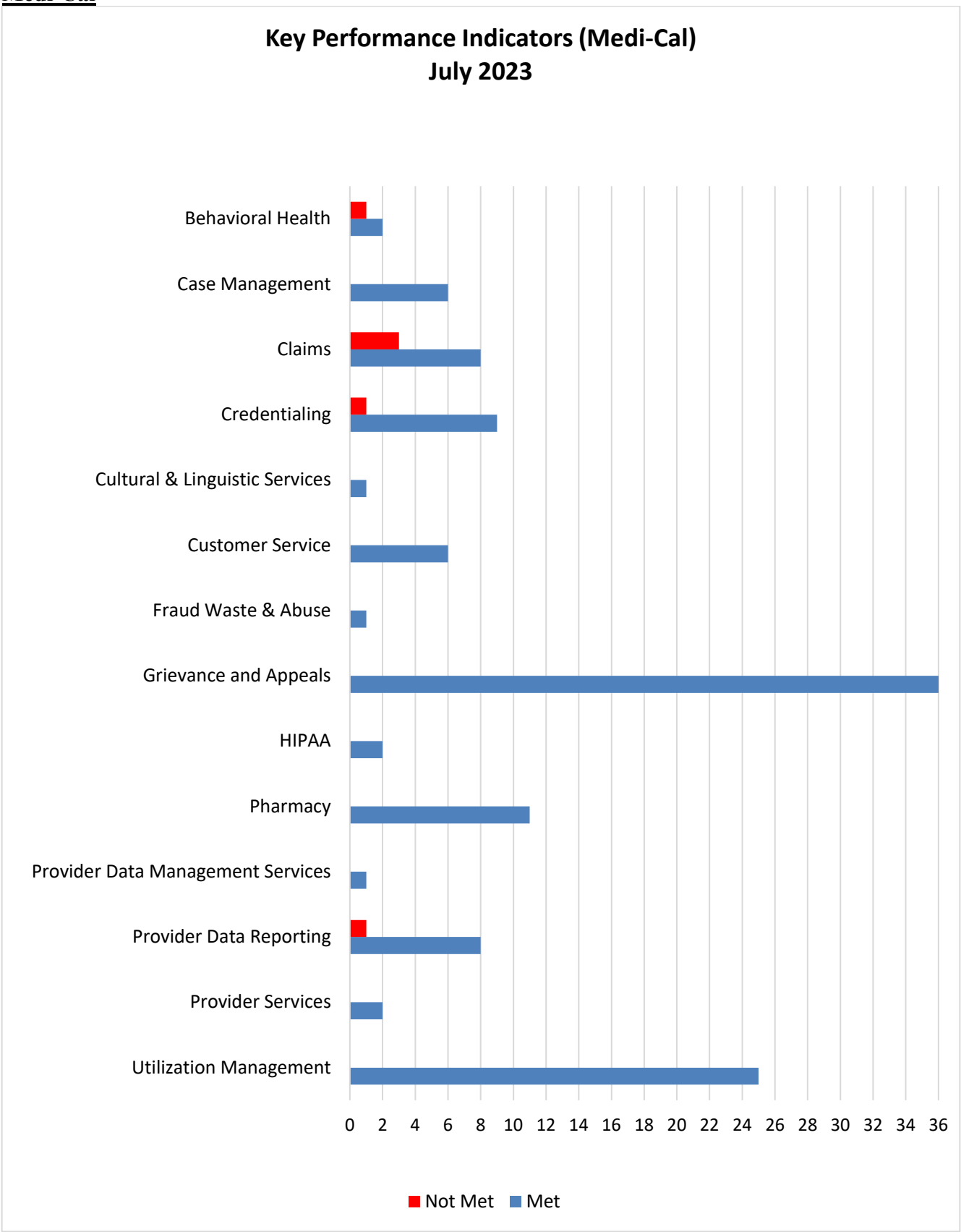
- **Internal Key Performance Indicators (KPIs)**

  - The KPI's are collected monthly from the internal departments.

  - A corrective action plan (CAP) is issued to the department when a measurement scores below the department's threshold for three consecutive months. The Internal Audit department actively works with the department to remediate non-compliant scores.

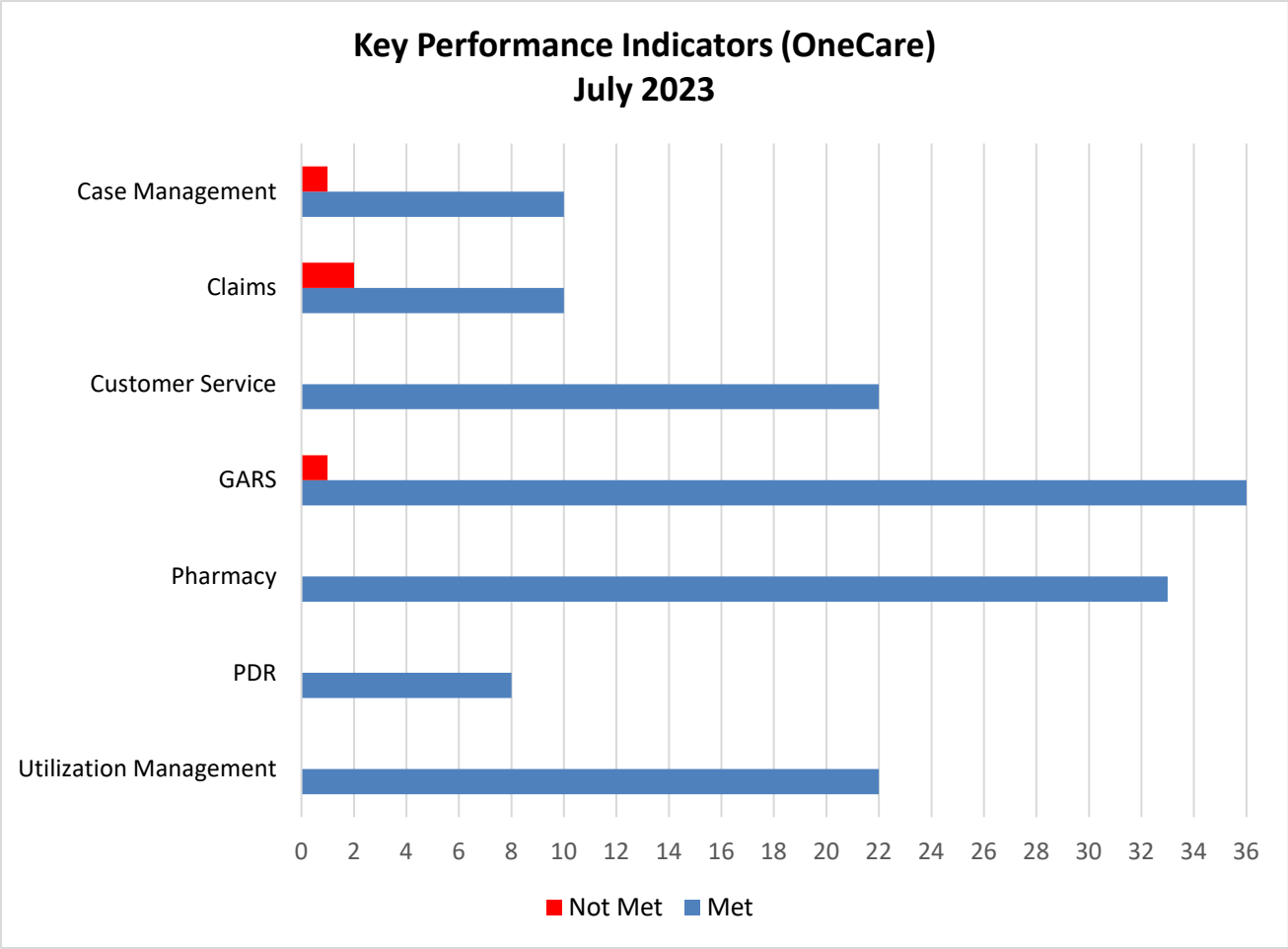
  - The charts below illustrate the number of KPIs for each functional area.
    - Red bar indicates the number of KPIs not met
    - Blue bar indicates the number of KPIs met

Medi-Cal

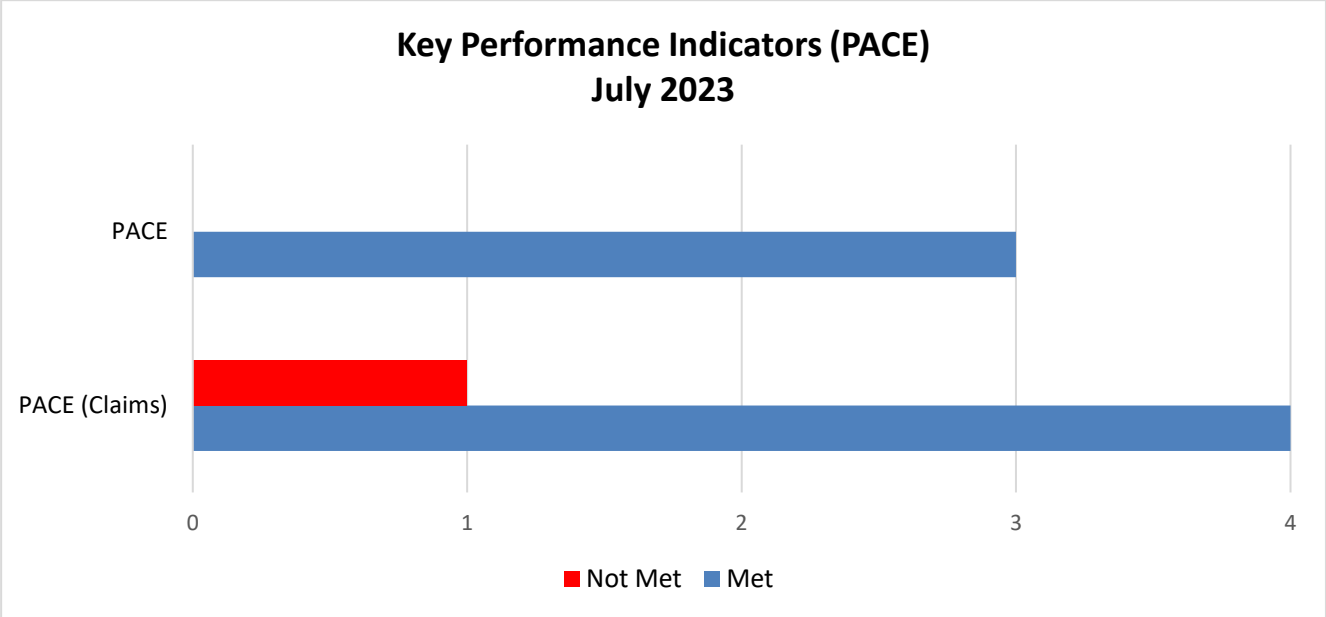


Back to Agenda

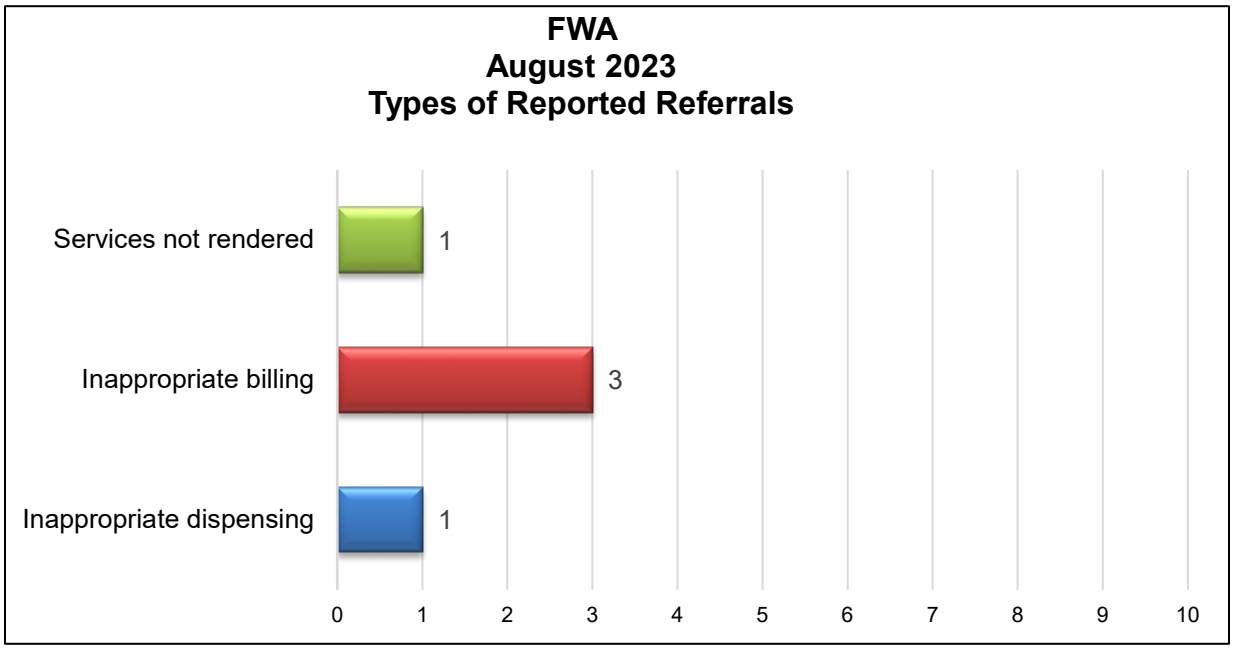
OneCare

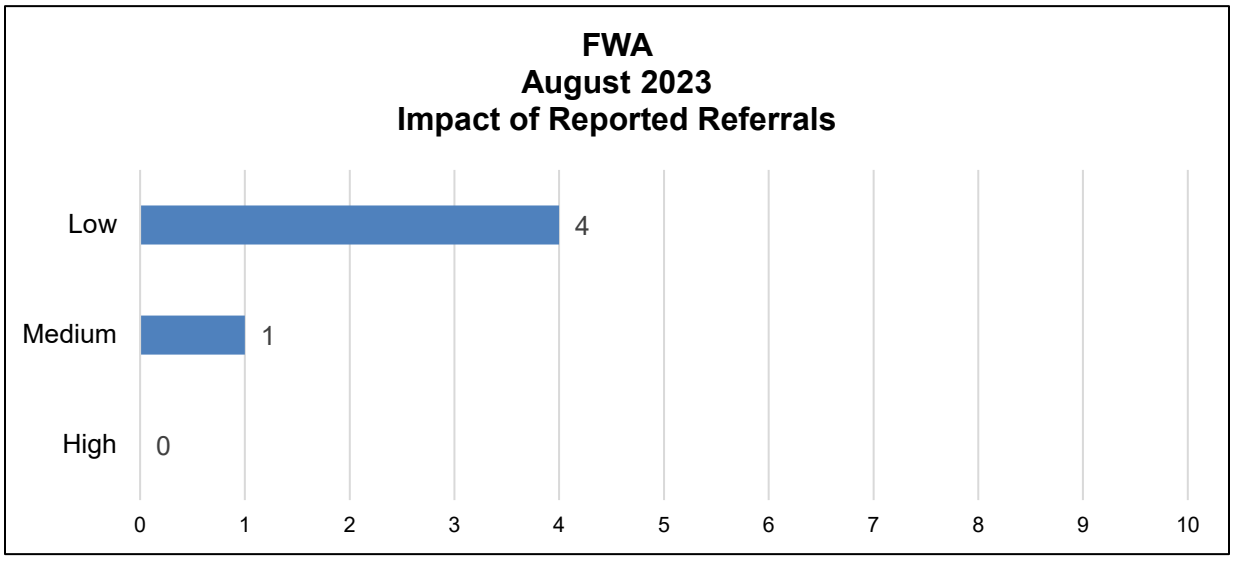


PACE



E. Fraud, Waste & Abuse (FWA) Investigations (August 2023)

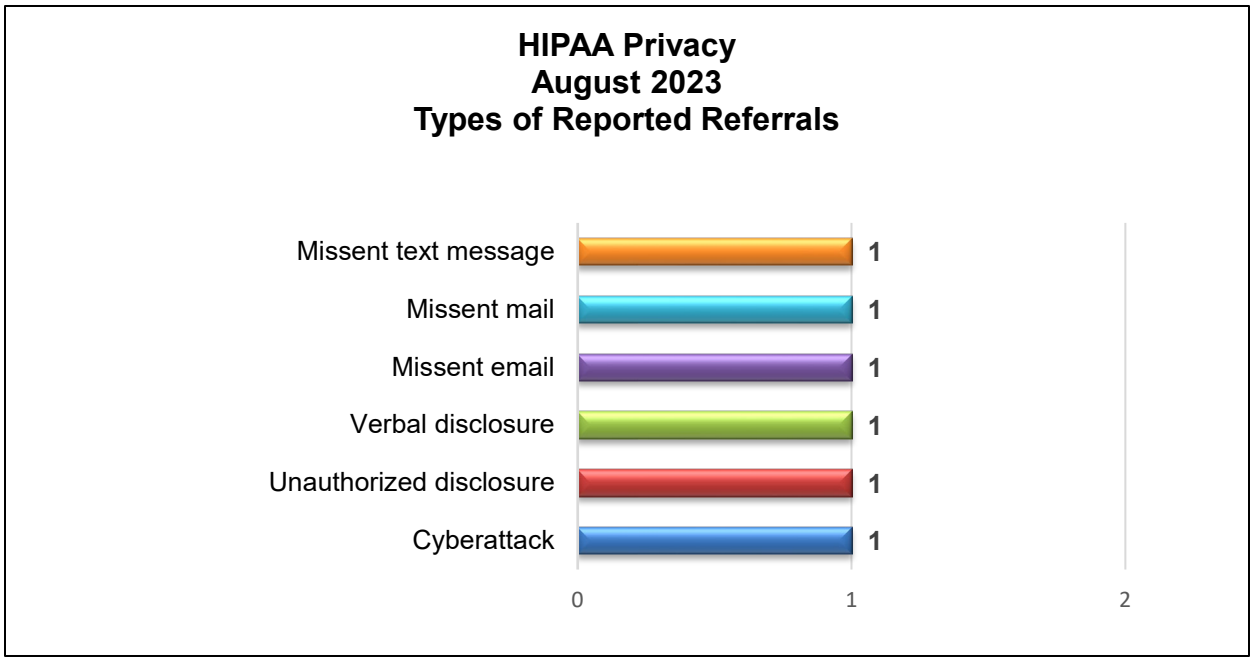


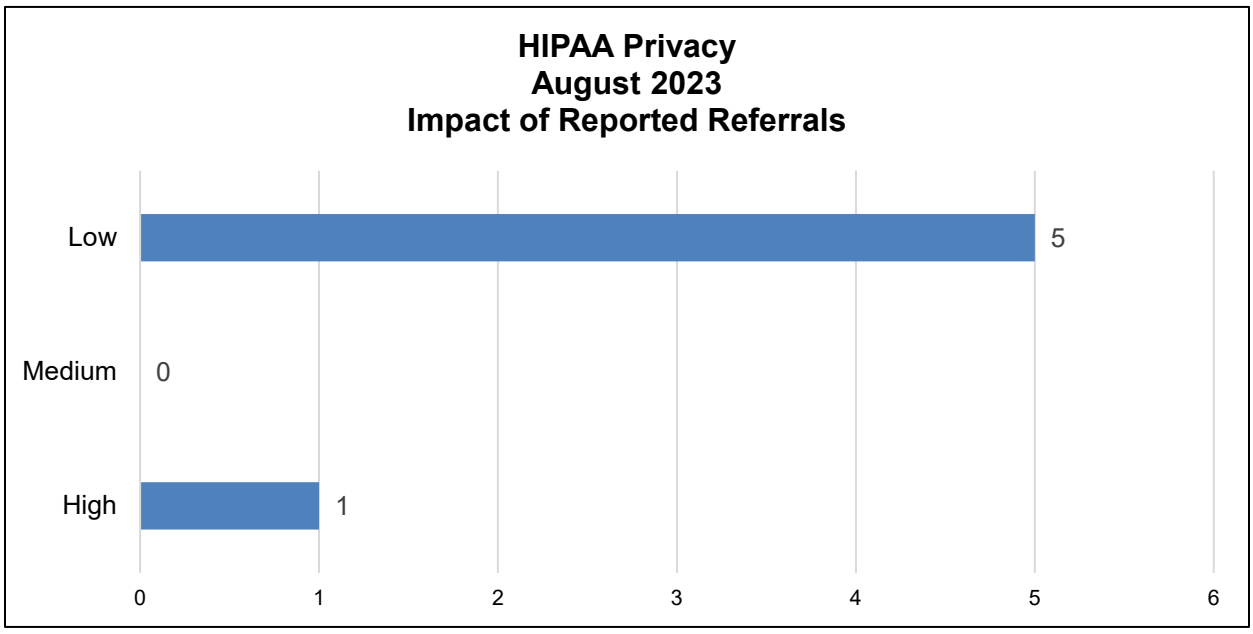


Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS*	3
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**5**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

F. Privacy Update: (August 2023)





Total Number of Referrals Reported to DHCS (State)	6
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

- **Notable Privacy/Security Event**

  - Prospect Medical Group (Prospect) experienced a cybersecurity incident in early August 2023.
  - Prospect serves as the Management Services Organization (MSO) for AMV Medical Group (AMVI) and United Care Medical Group (UCMG). Accordingly, the incident impacted these two groups as well.
  - CalOptima Health immediately terminated email and SFTP connection with Prospect (Prospect, AMVI, UCMG) as a security measure to limit CalOptima Health's risk.
  - Daily standups were immediately started internally and with Prospect to maintain communications on status of the incident.
  - Connection was re-established with Prospect email and SFTP on 9/6/23 upon CalOptima Health receiving satisfactory information from Prospect regarding forensic analysis and measures taken by Prospect to address the incident.
  - Prospect initiated appropriate protocols during the incident to ensure member access to care throughout the period of the incident.
  - CalOptima Health closely monitored grievances and appeals for Prospect (including AMVI and UCMG) throughout the incident for any change in pattern of member grievances and appeals – none were noted.
  - Prospect continues to actively investigate the matter and restore all systems full capacity.
  - CalOptima Health will continue to follow up with Prospect to determine if any CalOptima Health member data was compromised during the incident.
  - CalOptima Health has made appropriate Regulator Notifications and will monitor Prospect to ensure consistency and accuracy in reporting obligations going forward.

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

September 8, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: September Board of Directors Report

AUGUST RECESS

The House and Senate were in recess for the entire month of August. The Senate returned to session on September 5th. The House will return to session on September 12th.

FISCAL YEAR 2024 APPROPRIATIONS

When the House returns to session on September 12th, negotiations will resume on a Continuing Resolution (CR) to fund the government when Fiscal Year 2023 (FY23) ends on midnight September 30th. None of the 12 FY24 appropriations bills have been signed into law. House Speaker Kevin McCarthy (R-CA) has indicated he would support a short-term CR expiring in early December. However, negotiations between the House and Senate may prove difficult due to vast differences in spending priorities, topline spending caps, and efforts by House Republicans to repeal or defund programs authorized and funded in the *Inflation Reduction Act (IRA)*. In response, the White House has issued a veto threat on some of the bills in the House, with more veto threats expected should the rest of the bills move forward. The veto threats are available HERE and HERE.

Additionally, President Biden has requested a $40 billion emergency supplemental appropriations package. The package includes $24.1 billion for ongoing war efforts in Ukraine, with allocations of $13.1 billion for military aid, $8.5 billion for humanitarian and economic assistance, and funds for infrastructure programs via the World Bank. $12 billion is allocated for disaster relief, addressing natural disasters like the Vermont flooding and Hawaii wildfires. Security measures at the southern border would receive $4 billion, primarily for border management and migrant shelters, counter-fentanyl activities, and drug treatment and recovery support. The supplemental package is expected to be considered as part of the CR to fund the government beyond September 30th. More information is available HERE.

Back to Agenda

FARM BILL

Senate Majority Leader Chuck Schumer (D-NY) sent a letter (HERE) to colleagues at the end of August highlighting his priorities for September, which did not include a mention of the Farm Bill. The Farm Bill is a 5-year omnibus reauthorization that governs various agricultural and food programs, including the Supplemental Nutrition Assistance Program (SNAP). Neither the House nor the Senate have released a draft bill as of this report, a fairly unprecedented delay in the process with the 2018 Farm Bill expiring at the end of September. House and Senate Agriculture Committee staff have indicated that topline issues like payments to farmers have still not been decided, and there is a possibility of a one- or two-year extension of farm programs to keep agricultural markets and producers stable.

CMS DRAFT GUIDANCE – MEDICARE PRESCRIPTION PAYMENT PLAN REQUIREMENTS

On Monday, August 21st, the Centers for Medicare & Medicaid Services (CMS) released draft guidance detailing the new Medicare Prescription Payment Plan requirements and procedures. Guidance focuses on assisting Medicare Part D sponsors and pharmacies. The guidance will be released in two parts, with the second part being released in early 2024, focusing on outreach, education, monitoring, and compliance. A fact sheet on the Medicare Prescription Payment Plan is available HERE, along with an implementation timeline HERE, and the full draft guidance HERE.

NEW PROPOSED RULE ON DISABILITY DISCRIMINATION

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has announced a proposed rule that prohibits discrimination on the basis of disability. The proposed rule focuses on multiple areas including medical decision biases, digital accessibility, accessible medical equipment standards, child welfare program requirements, a prohibition on life-value discrimination, and integrated service setting obligations. The proposed rule updates the current Section 504 regulations and is available for viewing and public comment HERE. A factsheet is available HERE.

MEDICARE SHARED SAVINGS PROGRAM SAVED MEDICARE $1.8 BILLION IN 2022

On August 24th, CMS announced that the Medicare Shared Savings Program saved $1.8 billion in 2022 for Medicare. As of January 2023, Shared Savings Program ACOs include over 573,000 participating clinicians who provide care to almost 11 million people with Medicare. Earlier this year, in the Calendar Year (CY) 2024 Physician Fee Schedule proposed rule, CMS proposed changes to the Medicare Shared Savings Program (HERE) aimed at promoting participation, equity, and program growth. More information on the Shared Savings Program is available HERE.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
September 25, 2023

Legislative Update

The California Legislature adjourned for interim recess on September 14, ending the first year of the 2023-2024 legislative session. There were over 600 active measures under consideration in the legislature in the last three days of the session. Governor Gavin Newsom has until October 14, to sign, veto, or approve without signing the approximately 850 remaining bills presented to him. Legislators will reconvene January 3, 2024.

This was the first legislative session overseen by new Assembly Speaker Robert Rivas (Hollister) and his leadership team. By all accounts, the session ended smoothly despite the mid-year leadership changeover. Speaker Rivas is expected to replace some committee chairs in December, including key roles in the Budget and Appropriations Committees. Assembly Health Committee Chair Jim Wood is expected to remain in his role.

At the end of August, Senator Mike McGuire (North Coast) announced he held the votes to be the next Senate leader succeeding Senate Pro Tem Toni Atkins, who will be termed out next year. His leadership transition is expected to be in spring 2024, serving as a short-term leader as he terms out in 2026.

Budget Update

The Governor signed the Budget Act, Budget Bill Junior and several trailer bills in July as part of the 2023-24 Budget Package. In late August and September the legislature passed an additional 13 budget bills, 11 of which were signed on September 13, 2023, by the Governor. These include budget trailer and omnibus bills dealing with a variety of issues. Those most relevant to CalOptima Health include:

SB 104 (Skinner) – SB 101 Budget Bill Amendments (Technical Changes/Corrections)

Healthcare changes include: 1-Expanding authority of the Department of Health Care Access and Information to develop/make available a naloxone nasal product. 2-Clarifies recipients of Budget Act augmentations to support the Promotoras de Salud Program. 3-Reappropriates/extends availability of state operations funding previously approved for healthcare workforce programs to align with local assistance fund availability. 3-Appropriates federal fund expenditure authority for DHCS to allow expenditure of recent awards of federal mental health grants. 4-Authorizes DHCS to increase licensing/certification fees for residential and outpatient substance use disorder treatment facilities by up to 20% per year through 2026-27 to reach a cumulative fee increase of 75%.

SB 137 (Budget Committee) – Health Omnibus Trailer Bill

This is a budget trailer bill that implements provisions of the 2023-24 budget package affecting health-related departments. Specifically, this bill extends the moratorium on new hospice provider licenses, establishes a new fee setting process for residential and outpatient substance abuse treatment providers, requires Senate confirmation of the director and chief medical officer appointments at the Emergency Medical Services Authority, delays implementation deadlines contained in SB 1076 of 2022, clarifies treatment team membership and information sharing related to AB 2317 of 2022, authorizes CalRx to develop over-the-counter naloxone products, and appropriates $56.2 million in federal block grant funds for substance abuse prevention and treatment.

Legislation Watch

AB 271 (Quirk-Silva) – Homeless Death Review Committee – *CalOptima Health Support*

Status: Passed Senate and Assembly with no "no" votes recorded. Governor signed bill 9/1/23.

Authorizes counties to establish a homeless death review committee for the purposes of gathering information to identify the root causes of death of homeless individuals and determine strategies to improve coordination of services for homeless. Establishes procedures for sharing/disclosing information by a homeless death review committee.

AB 1230 (Valencia) – Special Needs Plans – *CalOptima Health Watch*

Status: Two-year bill. Author pulled bill from committee hearing 4/20/23.

Directs DHCS to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans and Fully Integrated Dual Eligible Special Needs Plans to provide care to dual eligible beneficiaries. County Organized Health Systems expressed concerns about circumventing authority to exclusively contract with providers in their services areas.

SB 598 (Skinner) – Prior Authorization – *CalOptima Health Oppose*

Status: Bill died in Assembly Appropriations 9/1/23. Now SB 516 (Skinner) eligible to consider in January.

This bill sought to control health insurance plans' use of prior authorization to control costs. It waives prior authorization for clinicians who regularly have 90% of their prior authorizations approved. Although SB 598 died, it resurfaced as a "gut and amend" bill on September 13 as SB 516 (Skinner) and is eligible to be considered in January.

SB 43 (Eggman) – Gravely Disabled – *CalOptima Health Watch*

Status: Passed Senate and Assembly unanimously. Submitted to Governor 9/21/23.

This bill expands the definition of "gravely disabled," for purposes of involuntarily detaining an individual with a severe substance use disorder (SUD), or a co-occurring mental health (MH) disorder and a severe SUD, or chronic alcoholism that is unable to additionally provide for personal safety or necessary medical care. This bill deems statements of specified health practitioners, for purposes of an expert witness in a proceeding relating to the appointment or reappointment of a conservator, as not made inadmissible by the hearsay rule, as specified.

Proposition 1 – March 2024 – *CalOptima Health Watch*

Status: AB 531 and SB 326 passed both houses with SB 326 receiving unanimous support. They will be combined as Proposition 1 on the March 2024 Ballot. Submitted to Governor 9/21/23.

AB 531 (Irwin) – Behavioral Health Infrastructure Bond Act

Creates Behavioral Health Infrastructure Bond Act of 2024, to authorize general obligation bonds to finance permanent supportive housing for veterans/others, in unlocked and locked behavioral health treatment and residential settings those experiencing homelessness (or at risk) with severe behavioral health challenges. Allows for streamlined review for capital projects. Amended 9/11/23 to increase the bond $1.7 billion from the original $4.68 billion to $6.38 billion.

SB 326 (Eggman) – Behavioral Health Services Act

Revises the Mental Health Services Act (MHSA) as the Behavioral Health Services Act (BHSA) if voters approve amendments at March 5, 2024, statewide primary election. This bill clarifies that county behavioral health programs are permitted to use BHSA funds to treat primary substance use disorder conditions and makes conforming changes throughout the BHSA. This bill restructures current MHSA funding buckets and enhances the current process for local planning of various services funded by the BHSA, and for oversight, accountability, and reporting of BHSA funds.

Back to Agenda

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and substance use disorder (SUD) services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact**:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact**:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 43 Eggman	**Gravely Disabled Definition:** Effective January 1, 2026, would expand the definition of "gravely disabled" to include a condition resulting from a severe SUD, or a co-occurring mental health disorder and a severe SUD, as well as chronic alcoholism. Would also require the California Department of Health Care Services (DHCS) to submit a report to include the number of persons admitted or detained for grave disability. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health Medi-Cal members newly considered as gravely disabled.	**09/14/2023** Senate concurred in amendments; ordered to the Governor **09/01/2023** Passed Assembly floor **05/26/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 326 Eggman	**The Behavioral Health Services Act:** Would place this act on the March 5, 2024, statewide primary election ballot. If approved by voters, would rename the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), expand services to include SUDs, revise the distribution of up to $36 million for behavioral health workforce funding and remove provisions related to innovative programs by, instead, establishing priorities and a program — administered by counties — to provide a housing support service. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services and housing interventions for CalOptima Health members.	**09/14/2023** Senate concurred in amendments; ordered to the Governor **09/12/2023** Passed Assembly floor **05/24/2023** Passed Senate floor	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the DHCS to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or SUD treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 531 Irwin	**The Behavioral Health Infrastructure Bond Act of 2023:** Would place this bond act on the March 5, 2024, statewide primary election ballot. If approved by voters, would authorize $6.4 million in bonds to fund conversion, rehabilitation or new construction of supportive housing and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges. ***Potential CalOptima Health Impact*:** Increased behavioral health services and community supports for some CalOptima Health members.	**09/14/2023** Assembly concurred in amendments; ordered to the Governor **09/14/2023** Passed Senate floor **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**04/11/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition — regardless of duration and whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**04/10/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1451 Jackson	**Urgent and Emergency Mental Health and SUD Treatment:** By January 1, 2024, requires health plans to provide coverage for the treatment of urgent and emergency mental health and SUDs without prior authorization. **Potential CalOptima Health Impact:** Increased scope of and/or modified utilization management (UM) procedures for behavioral health services provided to CalOptima Health Medi-Cal members.	**09/15/2023** Signed into law	CalOptima Health: Watch
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/12/2023** Passed Senate floor; referred to Assembly for concurrence in amendments **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
Budget			
SB 101 Skinner **AB 102** Ting	**Budget Act of 2023:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2023–24. Total spending is $310.8 billion, of which $226 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**7/10/2023** Signed into law	CalOptima Health: Watch
AB 118 Committee on Budget	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2023-24 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**07/10/2023** Signed into law	CalOptima Health: Watch
AB 119 Committee on Budget	**Managed Care Organization (MCO) Provider Tax Trailer Bill:** Renews the MCO provider tax, retroactively effective April 1, 2023, through December 31, 2026, and restructures the tax tiers and amounts. Also creates the Managed Care Enrollment Fund to fund Medi-Cal programs. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**06/29/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**04/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**09/12/2023** Senate concurred in amendments; ordered to the Governor **09/11/2023** Passed Assembly floor **05/26/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Would require the Medi-Cal program to cover PrEP and PEP furnished by a pharmacist for up to a 90-day course. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**09/01/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **05/22/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, would add biomarker testing — subject to UM controls- — including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**09/14/2023** Senate concurred in amendments; ordered to the Governor **09/13/2023**Passed Assembly floor **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would add two SMBP device-related services — patient training and device calibration as well as 30-day data collection —as covered Medi-Cal benefits to promote the health of beneficiaries with high blood pressure (hypertension) or another diagnosis that supports the use of an at-home blood pressure monitor. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**09/13/2023** Senate concurred in amendments; ordered to the Governor **09/12/2023** Passed Assembly floor **05/25/2023** Passed Senate floor	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner Horvath	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Effective July 1, 2024, would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** E covered benefit for CalOptima Health Medi-Cal members.	**09/14/2023** Assembly concurred in amendments; ordered to the Governor **09/13/2023** Passed Senate floor **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would also allow perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would allow such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/06/2023** Passed Senate floor **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Would authorize extended Medi-Cal coverage for palliative care and hospice services after 21 years of age for individuals deemed eligible prior to that age. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members.	**09/14/2023** Assembly concurred in amendments; ordered to the Governor **09/13/2023** Passed Senate floor **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/12/2023** Passed Senate floor **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**04/18/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1060 Ortega	**Naloxone Hydrochloride:** Would add prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/12/2023** Passed Senate floor **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 1085 Maienschein	**Housing Support Services**: Would require DHCS, if the state has sufficient network capacity, to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/12/2023** Passed Senate floor **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 1644 Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
AB 1481 Boerner Horvath	**Medi-Cal Presumptive Eligibility for Pregnancy**: Would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). Would make a presumptively eligible pregnant person eligible for all covered Medi-Cal benefits, except for inpatient services and institutional long-term care. If an application for full-scope Medi-Cal benefits is submitted within 60 days of a PE4PP determination, PE4PP coverage would be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**09/12/2023** Assembly concurred in amendments; ordered to the Governor **09/11/2023** Passed Senate floor **05/25/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**03/27/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. The U.S. Department of Health and Human Services estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**09/11/2023** Senate concurred in amendments; ordered to the Governor **09/07/2023** Passed Senate floor **05/15/2023** Passed Assembly floor	CalOptima Health: Watch
AB 719 Boerner Horvath	**Public Transit Contracts**: Would require Medi-Cal managed care plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would require reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**09/12/2023** Assembly concurred in amendments; ordered to the Governor **09/11/2023** Passed Senate floor **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1202 Lackey	**Health Care Services Data for Children, Pregnancy and Postpartum:** No later than January 1, 2025, would require DHCS to report to the Legislature the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. The report would also include data on the number of children, pregnant and postpartum individuals receiving certain Medi-Cal services. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/12/2023** Passed Senate floor **05/31/2023** Passed Assembly	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal program and CalOptima Health care delivery, financing and administration.	**02/17/2023** Introduced	CalOptima Health: Watch
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the Centers for Medicare and Medicaid Services (CMS) for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS. This would allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**09/13/2023** Senate concurred in amendments; ordered to the Governor **09/12/2023** Passed Assembly floor **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support CalPACE: Support
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**03/02/2023** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**03/13/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch LHPC: Oppose
Providers			
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 598 Skinner **SB 516** Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2026, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. Would also broadly prohibit prior authorization requirements for any services approved by a health plan at least 95% of the time. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider approval rates; decreased number of prior authorizations.	**09/13/2023** SB 516 gutted and amended as new vehicle for SB 598; re-referred to Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	**08/30/2023** CalOptima Health: OPPOSE CAHP: Oppose LHPC: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by CDPH. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**08/16/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **05/04/2023** Passed Senate floor	CalOptima Health: Watch
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 815 Wood	**Provider Credentialing**: Would require CalHHS to create a provider credentialing board that certifies entities to credential providers in lieu of a health plan's credentialing process, effective July 1, 2025. Would require a health plan to accept a credential from such entities without imposing additional criteria and to pay a fee to such entities based on the number of contracted providers credentialed. Health plans could use their own credentialing processes for any providers who are not credentialed by certified entities. ***Potential CalOptima Health Impact***: Reduced credentialing application workload for CalOptima Health staff; reduced quality oversight of contracted providers.	**06/07/2023** Referred to Senate Health Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Concerns LHPC: Oppose Unless Amended
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, would require a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing; additional staff time for program management.	**09/13/2023** Assembly concurred in amendments; ordered to the Governor **09/12/2023** Passed Senate floor **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would prohibit health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**09/11/2023** Assembly concurred in amendments; ordered to the Governor **09/07/2023** Passed Senate floor **05/01/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1241 Weber	**Medi-Cal Telehealth Access:** Requires Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this does not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video and audio-only health care services for CalOptima Health Medi-Cal members.	**09/08/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of an SUD, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**09/14/2023** Assembly concurred in amendments; ordered to the Governor **09/05/2023** Passed Senate floor **05/18/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with pharmacy benefit managers (PBMs) under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to Committees	CalOptima Health: Watch
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**03/24/2023** Passed by House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 282 Eggman	**Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**07/12/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**06/15/2023** Referred to Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 525 Durazo	**Health Care Workers Minimum Wage:** Would establish three separate minimum wage schedules for covered health care employers, including integrated health care delivery systems; health care systems; dialysis clinics; health facilities owned, affiliated, or operated by a county; licensed skilled nursing facilities; and clinics that meet certain requirements. ***Potential CalOptima Health Impact:*** Increased direct wage costs for certain CalOptima Health PACE employees to be incorporated into DHCS rates; increased indirect costs from contracted providers subject to wage increases**.**	**09/14/2023** Senate concurred in amendments; ordered to the Governor **09/01/2023** Passed Assembly floor **05/31/2023** Passed Senate floor	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**04/26/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**03/27/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**09/11/2023** Passed Senate floor; ordered to the Governor **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, including staffing, the intensity of activities taking place in an average visit, the length or duration of a visit, and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability of CalOptima Health's contracted FQHCs.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**02/17/2023** Introduced	CalOptima Health: Watch
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3746 McHenry	**Fiscal Responsibility Act (FRA) of 2023:** Suspends the $31 trillion debt limit until January 1, 2025, and includes additional policies to cap discretionary spending limits and modify work reporting requirements for certain safety net programs. Most notably, modifies work requirements for the Supplemental Nutrition Assistance Program (SNAP). Specifically, through October 1, 2030, raises the age of SNAP recipients subject to work requirements from 18–49 to 18–55 years old but also creates new exemptions that waive SNAP work requirements for veterans, individuals experiencing homelessness and young adults ages 18–24 years old who are aging out of the foster care system. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health members eligible for CalFresh.	**06/03/2023** Signed into law	CalOptima Health: Watch
AB 85 Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would also FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**09/14/2023** Assembly concurred in amendments; ordered to the Governor **09/13/2023** Passed Senate floor **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Authorizes counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**09/01/2023** Signed into law	**03/02/2023** CalOptima Health: SUPPORT

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: September 21, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2023–24 Enacted State Budget Analysis

Table of Contents

Background

On January 10, 2023, Gov. Gavin Newsom released the Fiscal Year (FY) 2023–24 Proposed State Budget, effective July 1, 2023. The proposed budget's total spending of $297 billion ($223.6 billion General Fund [GF]) reflected an estimated $22.5 billion deficit and a 9.8% decrease in overall spending compared to the FY 2022–23 Enacted Budget.

On May 12, Gov. Newsom released the FY 2023–24 Revised Budget Proposal, also known as the May Revise, with total funding at $306 billion, including $224 billion GF. As tax revenues continued to decline, the projected budget deficit increased by $9.3 billion compared to January Proposed Budget — totaling a $31.5 billion deficit. Nevertheless, the governor continued to present a balanced budget — largely without program cuts — through spending delays, shifts to funding sources, pullbacks of unused expenditures, new revenue sources, borrowing and limited reserve withdrawal.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 15, the State Senate and State Assembly both passed Senate Bill (SB) 101, a placeholder budget representing the Legislature's joint counterproposal to the May Revise. Once a final budget agreement deal was reached between the governor and legislative leaders, the governor signed into law the placeholder state budget (SB 101) on June 27 and the final, agreed-upon budget revisions (Assembly Bill [AB] 102) on July 10. In addition to the budget, the governor also signed the Managed Care Organization (MCO) Tax Trailer Bill (AB 119) on June 29 and the consolidated Health Trailer Bill (AB 118) on July 10, which contain the policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2023–24 Enacted Budget.

Overview

As the second largest budget in California history, the FY 2023–24 Enacted Budget sits at $310.8 billion, including nearly $226 billion GF spending, which attempts to close the gap on a $32 billion deficit while safeguarding $37.8 billion in reserve funds. This represents a 4.4% decrease in GF spending compared to the FY 2022–23 Enacted Budget ($234.4 billion GF). To achieve a balanced budget this FY, certain commitments will be delayed or added to the FY 2024–25 budget as a future investment.

The enacted budget estimates Medi-Cal spending of $151.2 billion ($37.6 billion GF), an 11.7% total increase (21.7% GF increase) from FY 2022–23, despite the fact that average Medi-Cal caseload in FY 2023–24 is expected to decrease by 7.2% to 14.2 million beneficiaries

as redeterminations resume following the end of the COVID-19 public health emergency (PHE). Total COVID-19-specific impacts on the Medi-Cal budget impacts are projected to decline overall, but GF costs are predicted to increase due to the phase-out of federal relief funding related to the PHE.

Managed Care Organization (MCO) Provider Tax

With renewed commitments to Medi-Cal spending, the enacted budget retroactively implements a new MCO Provider Tax, effective April 1, 2023, through December 31, 2026. Over the period of the tax, a total of $19.4 billion in net benefits will be generated — with $8.3 billion allocated for GF offsets to support a balanced budget and the remaining $11.1 billion for historic new investments in the Medi-Cal program, including targeted increases to Medi-Cal rates, access and provider participation.

In facilitating the $11.1 billion allocation, the new Medi-Cal Provider Payment Reserve Fund will support investments in Medi-Cal that maintain and expand programs by increasing quality of health care delivery and reducing barriers to care. These funds will preserve eligibility and benefit expansions in the Medi-Cal program, strengthen the program's participation, especially in underserved areas and in primary and preventive care, and maximize opportunities to draw additional federal matching funds to the Medi-Cal program. While a detailed plan for most investments will be submitted as part of the FY 2024–25 budget next year, specific limited investments beginning in FY 2023–24 can be found below:

Rate Increases in the Medi-Cal Program: No sooner than January 1, 2024, reimbursement rates for primary care services (including nurse practitioners and physician assistants), maternity care (including obstetric and doula services), and certain outpatient non-specialty mental health services will increase to at least 87.5% of Medicare rates. This is an adjustment to base rates that takes into account current Proposition 56 supplemental payments and the elimination of AB 97 rate reductions for these services. Estimated costs to increase provider rates are $237.4 million ($98.2 million Medi-Cal Provider Payment Reserve Fund) in FY 2023–24 and $580.5 million ($240.1 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

Distressed Hospital Loan Program: $300 million is allocated to support not-for-profit and public hospitals facing closure or facilitating the reopening of a hospital. The Department of Health Care Access and Information (HCAI) and California Health Facilities Financing Authority will provide one-time interest-free cashflow loans of up to $150 million from the Medi-Cal Provider Payment Reserve Fund in FY 2023–24 and up to $150 million from the GF in the previous FY 2022–23 to distressed hospitals in need.

Small and Rural Hospital Relief Program: $52.2 million will support rural hospitals to meet compliance standards with the State's seismic mandate with $50 million one-time from the Medi-Cal Provider Payment Reserve and $2.2 million from the Small and Rural Hospital Relief Fund for assessment and construction.

Graduate Medical Education Program: In an effort to increase the number of primary and specialty care physicians in the state — based on demonstrated workforce needs and priorities — $75 million will be expended for the University of California to expand graduate medical education programs and annually thereafter.

Behavioral Health

The state budget continues to address gaps through renewed commitments to modernize current programs in the mental health continuum. The enacted budget includes $40 million ($20 million Mental Health Services Fund; $20 million federal funds) to continue reforming the behavioral health system. As part of the final budget agreement, DHCS will work to implement the governor's proposal to modernize the Mental Health Services Act as well as authorize a general obligation bond to fund the following:

- Unlocked community behavioral health residential settings
- Permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Housing for veterans experiencing or at risk of homelessness who have behavioral health conditions

988 Suicide and Crisis Program: $13.2 million in special funds and federal funds will support a five-year implementation plan for a comprehensive 988 system. Under the health trailer bill language, prior authorization will no longer be required for behavioral health crisis stabilization services and care but authorizes prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis provided through the 988 system. Additionally, a plan that provides behavioral health crisis services and is contacted by a 988 center or mobile crisis team must authorize post-stabilization care or arrange for prompt transfer of care to another provider within 30 minutes

of initial contact.

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Third Party Administrator (TPA): As part of the CYBHI mandate, an established statewide all-payer fee schedule will reimburse school-linked behavioral health providers who deliver services to students at or near a school-site. $10 million from the Mental Health Services Fund will be expended in support of the statewide infrastructure that will consolidate provider management operations to include credentialing, quality assurance, billing and claims.

CalHOPE: The CalHOPE program is a vital element of the statewide crisis support system. $69.5 million total funding will assist in continuing operations, including media messaging to destigmatize stress and anxiety as well as CalHOPE web services, warm line and partnership opportunities with up to 30 community-based organizations and over 400 peer crisis counselors.

CalFresh

CalFresh — California's implementation of the federal Supplemental Nutrition Assistance Program (SNAP) — sees $35 million in funding for the California Nutrition Incentive Program, which helps members purchase healthy food from farmers' markets. The Legislature also included a line item for $16.8 million in one-time funding to extend the sunset dates for a CalFresh fruit and vegetable pilot EBT program Market Match. For every benefit dollar spent, participants receive an additional dollar to spend on fruits and vegetables at a market within set parameters. The deal also includes $915,000 to trial monthly minimum CalFresh benefit increase from $23 to $50.

California Advancing and Innovating Medi-Cal (CalAIM)

Transitional Rent: DHCS successfully sought an amendment to the CalAIM Transitional Rent Waiver with a commitment of $17.9 million ($6.3 million GF) for an additional community support that may be offered by Medi-Cal MCPs. Under the DHCS budget, the new "Transitional Rent" community support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system.

Relatedly, the budget also includes an additional $40 million GF for the Provider Access and Transforming Health (PATH) initiative to assist providers with implementing community supports and enhanced care management (ECM) through CalAIM in clinics.

Justice Involved: CalAIM receives a commitment of $9.9 million total funding ($3.8 million GF) in FY 2023–24 for pre-release services, with an additional $225 million estimated subsidy through the PATH program to support correctional agencies in collaborating with county social services department planning and implementation of pre-release Medi-Cal enrollment services.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, BH-CONNECT receives $6.1 billion total ($306.2 million GF; $87.5 million Mental Health Services Fund; $2.1 billion Medi-Cal County Behavioral Health Fund; $3.6 billion federal funds) over a span of five years for DHCS and the California Department of Social Services (DSS) to implement this CalAIM program as soon as January 1, 2024. BH-CONNECT includes statewide and county opt-in components, including rent and temporary housing for up to six months for certain high-needs beneficiaries as well a behavioral health workforce initiative to expand provider capacity and services. DHCS will also seek federal approval of a Medicaid Section 1115 demonstration waiver to expand behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

As part of CalAIM Behavioral Health Payment Reform, the budget also provides $250 million GF one-time to support the non-federal share of behavioral health-related services. These funds will help mitigate a significant cash flow concern for counties as they transition from cost-based reimbursement to a fee schedule.

Community Assistance, Recovery and Empowerment (CARE) Act

With a renewed pledge to serve California's most severely impaired population who often struggle with homelessness or incarceration without treatment, the CARE Act receives funding of $52.3 million GF in FY 2023–24, $121 million GF in FY 2024-25 and $151.5 million GF in FY 2025–26 to support ongoing county behavioral health department costs. The CARE Act facilitates delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making competences. The program would connect a person in crisis with a court-ordered

care plan for up to 24 months as a diversion from homelessness, incarcerations, or conservatorship.

Medi-Cal Eligibility

Enrollment Navigators: In addition to the $60 million appropriated in FY 2022–23, $10 million from the GF will be invested into the Health Enrollment Navigators Project (AB 74) over four years. The project aims to promote outreach, enrollment and retention activities in vulnerable populations through partnerships with counties and community-based organizations. Target populations of priority include but are not limited to persons with mental health disorder needs, persons with disabilities, older adults, unhoused individuals, young people of color, immigrants and families of mixed immigration status.

Medi-Cal Expansion to Undocumented Individual: The enacted budget maintains $1.4 billion ($1.2 billion GF) in FY 2023–24 and $3.4 billion ($3.1 billion GF) at full operation, inclusive of In-Home Supportive Services (IHSS) costs, to expand full-scope Medi-Cal eligibility to all income-eligible adults ages 26–49, regardless of immigration status, on January 1, 2024.

Newborn Hospital Gateway: The Newborn Hospital Gateway system provides presumptive eligibility determinations through an electronic process for families to enroll a deemed eligible newborn into the Medi-Cal program from hospitals that elected to participate in the program. Effective July 1, 2024, all qualified Medi-Cal providers participating in presumptive eligibility programs must utilize the Newborn Hospital Gateway system via the Children's Presumptive Eligibility Program portal to report a Medi-Cal-eligible newborn born in their facilities within 72 hours after birth or one business day after discharge.

Whole Child Model (WCM): As part of the budget, WCM will be extended to 15 additional counties no sooner than January 1, 2025. Currently implemented in 21 counties, WCM integrates children's specialty care services provided in the California Children's Services (CCS) program into Medi-Cal managed care plans (MCPs). WCM is already implemented in Orange County. The budget also requires a Medi-Cal MCP participating in WCM to ensure that a CCS-eligible child has a primary point of contact that will be responsible for the child's care coordination and support the referral pathways in non-WCM counties.

Miscellaneous

The enacted budget includes several other adjustments and provisions that potentially impact CalOptima Health:

- **COVID-19 Response:** a one-time funding of $126.6 million will continue ongoing efforts to protect the state's public health against COVID-19 – including maintenance of reporting systems, lab management and CalCONNECT — for oversight case and outbreak investigation.
- **Hepatitis C Virus Equity:** $10 million one-time GF spending, spanning over five years, to expand Hepatitis C Virus services — including outreach, linkage and testing — among high priority populations including young people who use drugs, indigenous communities and those experiencing homelessness.
- **Medi-Cal Rx Naloxone Access Initiative:** a one-time $30 million Opioid Settlements Fund expenditure to support the creation or procurement of a lower cost generic version of naloxone nasal product.
- **Medi-Cal Rx Reproductive Health Costs:** a one-time $2 million GF reappropriation and permissive use of funds for reproductive health care – including statutory changes to provide flexibility for the Medi-Cal Rx program to acquire various pharmaceutical drugs — Mifepristone or Misoprostol — to address urgent and emerging reproductive health needs.
- **Public Health Workforce:** upholds $97.5 million GF over four years for various public health workforce training and development programs.
- **Reproductive Waiver:** $200 million total funds to implement the Reproductive Health Services 1115 demonstration waiver that will support access to family planning and related services for Medi-Cal members as well as support sustainability and system transformation for California's reproductive health safety net.

Next Steps

State agencies will begin implementing the policies included in the enacted budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima Health. In addition, the Legislature will continue to advance policy bills through the legislative process.

Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 14 to pass legislation, and Gov. Newsom has until October 14 to either sign or veto that legislation.

About CalOptima Health

CalOptima Health, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima Health is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

CalOptima Health Community Outreach Summary — September and October 2023

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups, as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

To help families prepare their children for the beginning of the new school year, CalOptima Health hosted a Back-to-School Event on August 26 at St. Anthony Claret Catholic Church to celebrate and promote community health and wellness. More than 3,000 community members attended the event. Through the combined efforts of our community and health care partners, we were able to connect families to 25 organizations, offer Medi-Cal and CalFresh application assistance, and distribute 130 cases of diapers and 1,150 food boxes to those in need. Additional support and services included:

- 1,185 taco meals
- 1,100 backpacks
- 540 bike helmets
- 1,308 school kits
- 300 pairs of sunglasses
- 60 haircuts
- 62 dental screenings
- 32 sports physicals
- 102 vision screenings accompanied by 98 eyeglasses

Summary of Public Activities

As of September 8, CalOptima Health plans to participate in, organize or convene 84 public activities in September and October. In September, there were 49 public activities, including 22 virtual community/collaborative meetings, three community-based presentations, 23 community events and one Health Network Forum. In October, there will be 35 public activities, including 18 virtual community/collaborative meetings, two community-based presentations, 13 community events, one Health Network Forum and one Cafecito meeting. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided one endorsement since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of Support for UCI's application for the United States Economic Development Administration's Regional Technology and Innovation Hubs designation and Strategy Development Grant.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the October 5, 2023, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in September and October 2023:

September 2023

September 1, Gift of History, hosted by the Children's Education Foundation of Orange County

- Sponsorship fee: $3,500; included one full page of CalOptima Health information, QR code on the back page of "Nothing Rhymes with Orange" book (shared with 30,000 Orange County third graders), and placement of CalOptima Health's logo on partner's website.

September 5, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Families Forward, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

September 7, 10 a.m.–1 p.m., Annual Health Fair, hosted by the Orange County Employees Association (OCEA)

OCEA Headquarters, 830 N. Ross St., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public.

September 7, 10:30 a.m.–1:30 p.m., Community Agency Resource Fair, hosted by the Garden Grove Unified School District (GGUSD)

GGUSD, 10331 Stanford Ave., Garden Grove

- At least one staff member attended (in-person).
- Health/resource fair, open to the public.

September 7, 5–7 p.m., Resource Evenings, hosted by Phoenix Arise

Parochial Hall, 120 N. Janns St., Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public.

September 9, 11 a.m.–2 p.m., Caring for Caregivers Resource Fair, hosted by the Office of Congressman Lou Correa

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

September 10, 11 a.m.–3 p.m., 5th Annual Grandparents Day, hosted by Olive Community Services

Mile Square Park, 16801 Euclid St., Fountain Valley

- Sponsorship fee: $1,000; included resource table at the event, logo on the event website, promotional materials and event table, verbal recognition during the event, and social media mentions.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 11, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Davis Elementary School, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

September 13, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Whitten Community Center, 900 S. Melrose St., Placentia

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

September 14, 11 a.m.–2 p.m., Health and Community Resource Fair, hosted by The United Domestic Workers of America

Santa Ana Zoo, 1801 E. Chestnut Ave., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 15, 9 a.m.–2p.m., Regional Conferences, hosted by Vision y Compromiso

Northgate Market, 1201 N. Magnolia St., Anaheim

- Sponsorship fee: $250; included five-minute speaking opportunity at the event and logo displayed on the PowerPoint presentation.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 16, 10 a.m.–1 p.m., Active Living Expo, hosted by the Huntington Beach Council on Aging

Senior Center in Central Park, 18041 Goldenwest St., Huntington Beach

- Sponsorship fee: $1,000; included resource table, agency's name displayed on banner; half-page ad in program; recognition from the main stage during the event; link to agency's website from the host website for six months; placement of agency's name/logo on banners to be placed around the senior center for two weeks before the event; logo on event's Passport to Health; agency's banner showcased in prominent area of the senior center the week before the event; and mention in a press release from City of Huntington Beach.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 16, 10 a.m.–2:30 p.m., Mental Health Summit, hosted by Big Brothers Big Sisters of Orange County

Samueli Academy, 1901 N. Fairview St., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 20, 10 a.m.–1 p.m., Senior Resource Fair, hosted by H. Louis Lake Senior Center

Community Meeting Center, 11300 Standford Ave., Garden Grove

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 21, 11 a.m.–1 p.m., Master Plan on Aging Resource Fair, hosted by Supervisor Vicente Sarmiento and Advance OC

Delhi Center, 505 E. Central Ave., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 22, Noon–2 p.m., Master Plan on Aging Resource Fair, hosted by Vice Chairman Do and Advance OC

Asian Garden Mall, 9200 Bolsa Ave., Westminster

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 22, 9 a.m.–12:30 p.m., Health Fair and Flu Clinic, hosted by City of Brea

Brea Senior Center, 500 S. Sievers Ave., Brea

- Registration fee: $250; included resource table, table sign displaying organization's name, and name on passport.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 22, 9 a.m.–1:30 p.m., Recovery Art Event, hosted by Pacific Clinics-Recovery Education

Pacific Clinics, 401 S. Tustin St., Orange

- Sponsorship fee: $250; included resource table, agency featured on event program and media, and program acknowledgment on quarter-size page inside event program.
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

September 23, 9 a.m.–1 p.m., Senior Appreciation Fun and Resource Fair, hosted by Councilmember Carlos Leon

Modjeska Park, 1331 S. Nutwood St., Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

September 25, 11 a.m.–3 p.m., Master Plan on Aging Resource Fair, hosted by Supervisor Doug Chaffee and Advance OC

Brookhurst Community Center, 2271 Crescent Ave., Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 27, Noon–1:30 p.m., Lunch and Learn Event, hosted by CalOptima Health

Oasis Senior Center, 801 Narcissus Ave., Corona Del Mar

- At least four staff members attended (in person).
- Health/resource fair, open to the public.

September 27, 10 a.m.–1 p.m., Knowledge and Health Fair Expo, hosted by Costa Mesa Senior Center

Costa Mesa Senior Center, 695 W. 19th St., Costa Mesa

- Registration fee: $250; included resource table, table sign displaying organization's name, and name on passport.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 28, 10 a.m.–2 p.m., Northgate Outreach, hosted by Northgate Market

Northgate Market, 770 S. Harbor Blvd., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 29, 2–6 p.m., Cultural Heritage and Community HOPE hosted by Abrazar

Midway Community Center, 14900 Park Ln., Midway City

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

September 30, 3–8:30 p.m., Mid-Autumn Children's Festival, hosted by Nguoi Viet

Westminster Civic Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: $2,500; included resource table; weekly promotion on Facebook page; multiple acknowledgments during stage program; on-stage recognition; newspaper, radio, and TV ad impressions; one-minute remarks to festival attendees on stage during the opening ceremony; logo prominently featured on event t-shirt; and additional banner placement throughout the festival.
- At least three staff members attended (in-person).
- Health/resource fair, open to the public.

September 30, 9 a.m.–2 p.m., Family Fiesta Resource Fair, hosted by Miraloma Park Family Resource Center

Miraloma Park Family Resource Center, 2600 E. Miraloma Way, Anaheim

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

September 30, 8 a.m.–Noon, Prostate Cancer Awareness Bike Ride hosted by Office of Supervisor Chaffee

Tri-City Regional Park, 2301 Kraemer Blvd., Placentia

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

October 2023

October 1, 5–8 p.m., Moon Festival, hosted by Viet America Society

Mile Square Park, 16801 Euclid St., Fountain Valley

- Sponsorship fee: $15,000; includes resource table, three banner displays, 20 mentions on stage, 25 radio impressions,15 television impressions, and LED backdrop projection of logo on stage.
- At least three staff members will attend (in person).
- Health/resource fair, open to the public.

October 5, 10 a.m.–1 p.m., Community Health and Resource Fair, hosted by Clinton Corner Family Campus

Clinton Corner Family Campus, 13581 Clinton St., Garden Grove

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 5, 8 a.m.–6 p.m., Annual Summit, hosted by Orange County Grantmakers

Orange Coast College, 2701 Fairview Rd., Costa Mesa

- Sponsorship fee: $2,500 includes resource table at the event, logo and link on website, social media, recognition as an event sponsor, two event tickets, logo and link on conference wrap-up e-communication, and logo and link on the summit webpage.
- At least three staff members to attend (in person).
- Health/resource fair, open to the public.

October 8, 8–11:30 a.m., Walk for Independence, hosted by Project Independence

Twinkle Park, 970 Arlington Dr., Costa Mesa

- Exhibitor fee: $200 includes resource table at event.
- At least two staff members to attend (in person).
- Health/resource fair, open to the public.

October 11, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

California State University Fullerton, 800 N. State College Blvd., Fullerton

- At least one staff member to present (in person).
- Community-based organization presentation, open to members/community.

October 12, Noon–2 p.m., Master Plan on Aging Resource Fair, hosted by Chairman Wagner and Advance OC

Norman Murray Senior Center, 24932 Veterans Way, Mission Viejo

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 12, 6–7 p.m., CalOptima Health Medi-Cal Overview in Spanish

La Habra Family Resource Center, 501 S. Idaho St., La Habra

- At least one staff member to present (in person).
- Community-based organization presentation, open to members/community.

October 12–15, 10 a.m.–10 p.m., Arirang Festival, hosted by Korean Festival Committee of Orange County

Garden Grove Park, 9301 Westminster Blvd., Garden Grove

- Sponsorship fee: $2,500 includes resource tables at the event.
- At least three staff members to attend (in person).
- Health/resource fair, open to the public.

October 14, 9 a.m.–Noon, Out of the Darkness Walk, hosted by American Foundation of Suicide Prevention

Mason Regional Park, 18712 University Dr., Irvine

- Registration fee: $75; includes resource table at event.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 17, 10 a.m.–Noon, Costa Mesa Senior Scam Stopper, hosted by Office of Assemblywoman Cottie Petrie-Norris

Costa Mesa Senior Center, 695 W. 19th St., Costa Mesa

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 18, 10 a.m.–Noon, Community Resource Fair, hosted by Equus Workforce Solutions

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 19, 9:30–11:30 a.m., Tustin Senior Scam Stopper, hosted by Office of Assemblywoman Cottie Petrie-Norris

Tustin Area Senior Center, 200 S. C St., Tustin

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 21, 9:30–11:30 a.m., Walk to End Alzheimer's, hosted by Alzheimer's Association

Mike Ward Community Park, 20 Lake Rd., Irvine

- Sponsorship fee: $1,500; includes resource table at event and logo on event website.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

October 21, 9 a.m. –1 p.m., Medi-Cal Renewal and CalFresh Event, hosted by CalOptima Health

Free Chape, 2777 McGaw Ave., Irvine

- At least six staff members to attend (in person).
- Health/resource fair, open to the public.

October 27, 8:30 a.m.–3:30 p.m., Master Plan on Aging Resource Fair hosted by Supervisor Katrina Foley and Advance OC

Soka University, 1 University Dr., Aliso Viejo

- At least four staff members to attend (in person).
- Steering committee meeting, open to collaborative members.

October 31, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health

Virtual

- At least six staff members to attend.
- Health/resource fair, open to the public.

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

9. Recommend that the Board of Directors Accept, Receive and File Fiscal Year 2022-23 CalOptima Health Audited Financial Statements

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Recommend that the CalOptima Health Board of Directors (Board) accept, receive and file the Fiscal Year (FY) 2022-23 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss Adams, LLP (Moss Adams).

Background

CalOptima Health contracted with financial auditors, Moss Adams to complete CalOptima Health's annual financial audit. At the May 18, 2023, meeting of the CalOptima Health Finance and Audit Committee, Moss Adams presented the FY 2022-23 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit and review of relevant internal controls and compliance for CalOptima Health's major programs.

Discussion

Moss Adams conducted the interim audit beginning on May 22, 2023, and the year-end audit was conducted during July to August 2023. This year's significant audit areas that Moss Adams reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables; and
- Amounts due to the State of California or the California Department of Health Care Services.

Results from CalOptima Health's FY 2022-23 audit were positive. Moss Adams:

- Made no changes to CalOptima Health's approach to applying critical accounting policies;
- Did not report any significant difficulties during the audit; and
- Identified no material misstatements or control deficiencies.

As such, management recommends that the Board accept the CalOptima Health FY 2022-23 audited financial statements as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

Back to Agenda

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments

1. FY 2022-23 CalOptima Health Audited Financial Statements
2. Presentation by Moss Adams, LLP

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

Report of Independent Auditors and Financial Statements with Supplementary Information

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

June 30, 2023 and 2022

MOSSADAMS

Back to Item

Back to Agenda

Table of Contents

Back to Item

Back to Agenda

Management's Discussion and Analysis

Back to Item

Back to Agenda

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima Health's financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2023, 2022, and 2021. Readers should review this summation in conjunction with CalOptima Health's financial statements and accompanying notes to the financial statements to enhance their understanding of CalOptima Health's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima Health for the fiscal years ended June 30, 2023, 2022, and 2021:

Key Operating Indicators	2023	2022	2021
Members (at end of fiscal period)			
Medi-Cal program	$ 970,590	$ 897,134	$ 825,076
OneCare	17,687	2,668	1,934
OneCare Connect	-	14,415	14,833
PACE	439	429	398
Average member months			
Medi-Cal program	940,893	859,290	793,023
OneCare	17,443	2,342	1,669
OneCare Connect	14,360	14,682	14,704
PACE	434	417	389
Operating revenues (in millions)	$ 4,239	$ 4,227	$ 4,148
Operating expenses (in millions)			
Medical expenses	3,862	3,946	3,729
Administrative expenses	192	150	141
Operating income (in millions)	$ 184	$ 131	$ 278
Operating revenues PMPM (per member per month)	$ 369	$ 402	$ 427
Operating expenses PMPM			
Medical expenses PMPM	336	375	384
Administrative expenses PMPM	17	14	15
Operating income PMPM	$ 16	$ 13	$ 28
Medical loss ratio	91%	93%	90%
Administrative expenses ratio	4.5%	3.6%	3.4%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 90	$ 168	$ 154
Administrative expenses (in millions)	$ 92	$ 166	$ 150

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect CalOptima Health's financial position as of June 30, 2023, 2022, and 2021, and the results of its operations for the fiscal years ended June 30, 2023, 2022, and 2021. The financial statements of CalOptima Health, including the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows, represent the accounts and transactions of the five (5) lines of business – Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and Multipurpose Senior Services Program (MSSP).

- The statements of net position include all of CalOptima Health's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of the CalOptima Health Board of Directors (Board) policy.

- The statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal years and the resulting increase or decrease in net position.

- The statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis addresses CalOptima Health's overall program activities. CalOptima Health's Medi-Cal program accounted for 89.8 percent, 90.0 percent, and 90.2 percent of its annual revenues during fiscal years 2023, 2022, and 2021, respectively. CalOptima Health's OneCare program accounted for 5.1 percent, 0.9 percent, and 0.6 percent of its annual revenues during fiscal years 2023, 2022, and 2021, respectively. CalOptima Health's OneCare Connect program accounted for 4.1 percent, 8.1 percent, and 8.3 percent of its annual revenues during fiscal years 2023, 2022, and 2021, respectively. All other programs in aggregate accounted for 1.1 percent, 1.0 percent, and 0.9 percent of CalOptima Health's annual revenues during fiscal years 2023, 2022, and 2021, respectively.

2023 and 2022 Financial Highlights

As of June 30, 2023 and 2022, total assets and deferred outflows of resources were approximately $3,624.3 million and $3,025.6 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,670.0 million and $1,419.5 million, respectively.

Net position increased by approximately $250.5 million, or 17.6 percent, during fiscal year 2023 and increased by approximately $110.7 million, or 8.5 percent, during fiscal year 2022.

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

Financial Position	2023	(As restated) 2022	Change from 2022 Amount	Change from 2022 Percentage
ASSETS				
Current assets	$ 2,937,296	$ 2,337,407	$ 599,889	25.7%
Board-designated assets and restricted cash	576,852	611,428	(34,576)	-5.7%
Capital assets, net	66,189	66,864	(675)	-1.0%
Intangible right-to-use subscription asset	18,018	261	17,757	100.0%
Total assets	3,598,355	3,015,960	582,395	19.3%
DEFERRED OUTFLOWS OF RESOURCES	25,969	9,626	16,343	169.8%
Total assets and deferred outflows of resources	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%
LIABILITIES				
Current liabilities	$ 1,871,529	$ 1,551,389	$ 320,140	20.6%
Other liabilities	59,440	22,756	36,684	161.2%
Subscription liability, net of current portion	12,173	141	12,032	100.0%
Total liabilities	1,943,142	1,574,286	368,856	23.4%
DEFERRED INFLOWS OF RESOURCES	11,176	31,790	(20,614)	-64.8%
NET POSITION				
Net investment in capital assets	66,134	66,772	(638)	-1.0%
Restricted by legislative authority	107,969	107,346	623	0.6%
Unrestricted	1,495,903	1,245,392	250,511	20.1%
Total net position	1,670,006	1,419,510	250,496	17.6%
Total liabilities, deferred inflows of resources, and net position	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%

Current assets increased $599.9 million from $2,337.4 million in 2022 to $2,937.3 million in 2023, primarily in cash and investments. Cash and investments had a net increase of $575.8 million primarily from increased enrollment and premium capitation rates. Current liabilities increased $320.1 million from $1,551.4 million in 2022 to $1,871.5 million in 2023 driven primarily by payables due to the State of California (the "State") for the COVID-19 risk corridor for the period of July 1, 2019 through April 30, 2023, the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridors for the period of January 1, 2021 through June 30, 2023, and the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 2023. In May 2023, the State finalized the Bridge Period (July 1, 2019 through December 31, 2020) Proposition 56 risk corridor and a payment was remitted to the State on June 2023 in the amount of $74.5 million.

Board-designated assets and restricted cash decreased by $34.6 million and $34.6 million in fiscal years 2023 and 2022, respectively, primarily driven by changes to the portfolio's valuation. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for homeless health initiatives (HHI) on April 4, 2019. On September 1, 2022, the Board approved a reallocation of the remaining $40.1 million from HHI to the state Housing and Homelessness Incentive Program initiatives. As of June 30, 2023, the balance of the HHI reserve was $21.0 million.

The Board's policy is to augment the rest of the Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months in consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2023, is at 1.78 times the monthly average consolidated capitation revenue.

CalOptima Health is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act").

2022 and 2021 Financial Highlights

As of June 30, 2022 and 2021, total assets and deferred outflows of resources were approximately $3,025.5 million and $2,540.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1.419.5 million and $1,308.8 million, respectively.

Net position increased by approximately $110.7 million, or 8.5 percent, during fiscal year 2022 and increased by approximately $283.7 million, or 27.7 percent, during fiscal year 2021.

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

Financial Position	(As restated) 2022	2021	Change from 2021 Amount	Change from 2021 Percentage
ASSETS				
Current assets	$ 2,337,407	$ 1,834,119	$ 503,288	27.4%
Board-designated assets and restricted cash	611,428	645,979	(34,551)	-5.3%
Capital assets, net	66,864	45,728	21,136	46.2%
Intangible right-to-use subscription asset	261	-	261	0.0%
Total assets	3,015,960	2,525,826	490,134	19.4%
DEFERRED OUTFLOWS OF RESOURCES	9,626	14,992	(5,366)	-35.8%
Total assets and deferred outflows of resources	$ 3,025,586	$ 2,540,818	$ 484,768	19.1%
LIABILITIES				
Current liabilities	$ 1,551,389	$ 1,165,444	$ 385,945	33.1%
Other liabilities	22,756	62,230	(39,474)	-63.4%
Subscription liability, net of current portion	141	-	141	0.0%
Total liabilities	1,574,286	1,227,674	346,612	28.2%
DEFERRED INFLOWS OF RESOURCES	31,790	4,363	27,427	628.6%
NET POSITION				
Net investment in capital assets	66,772	45,601	21,171	46.4%
Restricted by legislative authority	107,346	101,509	5,837	5.8%
Unrestricted	1,245,392	1,161,671	83,721	7.2%
Total net position	1,419,510	1,308,781	110,729	8.5%
Total liabilities, deferred inflows of resources, and net position	$ 3,025,586	$ 2,540,818	$ 484,768	19.1%

Current assets increased $503.3 million from $1,834.1 million in 2021 to $2,337.4 million in 2022, primarily in cash and investments. Cash and investments had a net increase of $490.7 million primarily from increased enrollment and premium capitation rates. Current liabilities increased $385.9 million from $1,165.4 million in 2021 to $1,551.4 million in 2022 driven primarily by payables due to the State for the COVID-19 (previously called Gross Medical Expense (GME)) risk corridor for the period of July 1, 2019 through June 30, 2022, the Proposition 56 risk corridors for the period of July 1, 2019 through June 30, 2022, and the ECM risk corridor for the period of January 1, 2022 through June 30, 2022.

Board-designated assets and restricted cash decreased by $34.6 million and increased by $3.6 million in fiscal years 2022 and 2021, respectively, primarily driven by a portfolio valuation change. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for HHI on April 4, 2019. As of June 30, 2022, the balance of the HHI reserve was $40.6 million.

The Board's policy is to augment the rest of the Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2022, was at 1.75 times of monthly average consolidated capitation revenue.

CalOptima Health's Board-designated assets also include the requirement to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act").

2023 and 2022 Results of Operations

CalOptima Health's fiscal year 2023 operating and non-operating revenues resulted in a $250.5 million increase in net position, $139.8 million more compared to a $110.7 million increase in fiscal year 2022. The following table reflects the changes in revenues and expenses for 2023 compared to 2022:

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

Results of Operations	2023	(As restated) 2022	Change from 2022 Amount	Change from 2022 Percentage
PREMIUM REVENUES	$ 4,239,833	$ 4,227,259	$ 12,574	0.3%
Total operating revenues	4,239,833	4,227,259	12,574	0.3%
MEDICAL EXPENSES	3,862,196	3,945,849	(83,653)	-2.1%
ADMINISTRATIVE EXPENSES	192,339	150,443	41,896	27.8%
Total operating expenses	4,054,535	4,096,292	(41,757)	-1.0%
OPERATING INCOME	185,298	130,967	54,331	41.5%
NONOPERATING REVENUES AND EXPENSES	65,198	(20,238)	85,436	-422.2%
Increase in net position	250,496	110,729	139,767	126.2%
NET POSITION, beginning of year	1,419,510	1,308,781	110,729	8.5%
NET POSITION, end of year	$ 1,670,006	$ 1,419,510	$ 250,496	17.6%

2023 and 2022 Operating Revenues

The increase in operating revenues of $12.6 million in fiscal year 2023 is primarily attributable to an increase in enrollment of 11.0 percent which resulted in additional revenue of $216.4 million and $50.0 million in revenue from programs such as the HHIP, California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP), and Student Behavioral Health Incentive Program (SBHIP). The increase in revenue is offset by net additional payables due to the State for the COVID-19, Proposition 56, and ECM risk corridor estimates.

2023 and 2022 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 8.4 percent from fiscal year 2022 to fiscal year 2023. Capitated member enrollment accounted for approximately 73.4 percent of CalOptima Health's enrollment, averaging 690,882 members during fiscal year 2023 and approximately 75.0 percent of CalOptima Health's enrollment, averaging 644,579 members during fiscal year 2022. Included in the capitated environment are 232,786 or 33.7 percent and 212,078 or 32.9 percent members in a shared risk network for fiscal years 2023 and 2022, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Provider capitation expenses totaled $1,155.2 million in fiscal year 2023, compared to $1,226.2 million in fiscal year 2022. The decrease reflects adjustments for Proposition 56 estimated accruals due to an updated logic that impacted prior years.

Claims expenses to providers and facilities, including long-term care (LTC) services, increased by 14.6 percent from fiscal year 2022 to fiscal year 2023 due to the release of In-Home Supportive Services (IHSS) estimates in fiscal year 2022 increased utilization from higher enrollment.

Prescription drug expenses decreased by $348.5 million due to the State's transition of pharmacy benefits to Medi-Cal Fee-for-Service beginning January 1, 2022.

In addition to the items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals decreased from $146.4 million to $0 from fiscal year 2022 to fiscal year 2023 due to the State's timing for QAF payments. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2023 and 2022 Administrative Expenses

Total administrative expenses were $192.3 million in 2023 compared to $150.4 million in 2022 . Overall administrative expenses increased by 27.8 percent or $41.9 million, primarily due to an increase in filled positions, cost of living and other salary adjustments, and adoption of the Government Accounting Standards Board (GASB) Statement No. 96 for Subscription-Based Information Technology Arrangements. In fiscal years 2023 and 2022 , CalOptima Health's administrative expenses were 4.5 percent and 3.6 percent of total operating revenues, respectively.

2023 and 2022 Non-Operating Revenues and Expenses

Non-operating revenue and expenses increased by $85.4 million from a loss of $20.2 million in fiscal year 2022 to income of $65.2 million in fiscal year 2023. The increase is driven primarily by net investment income in fiscal year 2023 of $90.4 million, an increase of $110.8 million from a net investment loss of $20.4 million in fiscal year 2022. The amount is offset by an increase in grant expenses of $25.5 million, from $121 thousand in fiscal year 2022 to $25.5 million in fiscal year 2023.

The Board and management have been accelerating efforts to improve access and quality of health care for the most vulnerable residents in Orange County. Those efforts included increasing the number of community investment grants released in the recent fiscal years.

2022 and 2021 Results of Operations

CalOptima Health's fiscal year 2022 operating and non-operating revenues resulted in a $110.7 million increase in net position, $172.9 million less compared to a $283.7 million increase in fiscal year 2021. The following table reflects the changes in revenues and expenses for 2022 compared to 2021:

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

Results of Operations	(As restated) 2022	2021	Change from 2021 Amount	Change from 2021 Percentage
PREMIUM REVENUES	$ 4,227,259	$ 4,148,336	$ 78,923	1.9%
Total operating revenues	4,227,259	4,148,336	78,923	1.9%
MEDICAL EXPENSES	3,945,849	3,729,469	216,380	5.8%
ADMINISTRATIVE EXPENSES	150,443	141,166	9,277	6.6%
Total operating expenses	4,096,292	3,870,635	225,657	5.8%
OPERATING INCOME	130,967	277,701	(146,734)	-52.8%
NONOPERATING REVENUES AND EXPENSES	(20,237)	5,949	(26,186)	-440.2%
Increase in net position	110,730	283,650	(172,920)	-61.0%
NET POSITION, beginning of year	1,308,781	1,025,131	283,650	27.7%
NET POSITION, end of year	$ 1,419,511	$ 1,308,781	$ 110,730	8.5%

2022 and 2021 Operating Revenues

The increase in operating revenues of $78.9 million in fiscal year 2022 is primarily attributable to an increase in enrollment of 8.6 percent which resulted in additional revenue of $162.0 million and increases in premium capitation rates for new programs, such as ECM, Community Supports, and COVID-19 testing and treatment services. The increase in revenue is offset by additional payables due to the State for the COVID-19, Proposition 56, and ECM risk corridor estimates.

2022 and 2021 Medical Expenses

Medi-Cal capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 8.3 percent from fiscal year 2021 to fiscal year 2022. Capitated member enrollment accounted for approximately 75.0 percent of CalOptima Health's enrollment, averaging 644,579 members during fiscal year 2022, and 75.0 percent of CalOptima Health's enrollment, averaging 595,103 members during fiscal year 2021. Included in the capitated environment are 212,078 or 32.9 percent and 192,076 or 32.3 percent members in a shared risk network for fiscal years 2022 and 2021, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal capitation expenses totaled $1,226.2 million in fiscal year 2022, compared to $1,170.0 million in fiscal year 2021. The increase reflects additional capitation expenses primarily due to increases in enrollment as the State paused redetermination of eligibility during the public health emergency.

Claims expense to providers and facilities, including LTC services, increased by 24.9 percent from fiscal year 2021 to fiscal year 2022 due to the release of IHSS estimates in fiscal year 2021 and increased utilization from higher enrollment.

Prescription drug expenses decreased by 45.0 percent in fiscal year 2022 compared to fiscal year 2021, primarily due to the State's transition of pharmacy benefits to Medi-Cal Fee-for-Service beginning January 1, 2022.

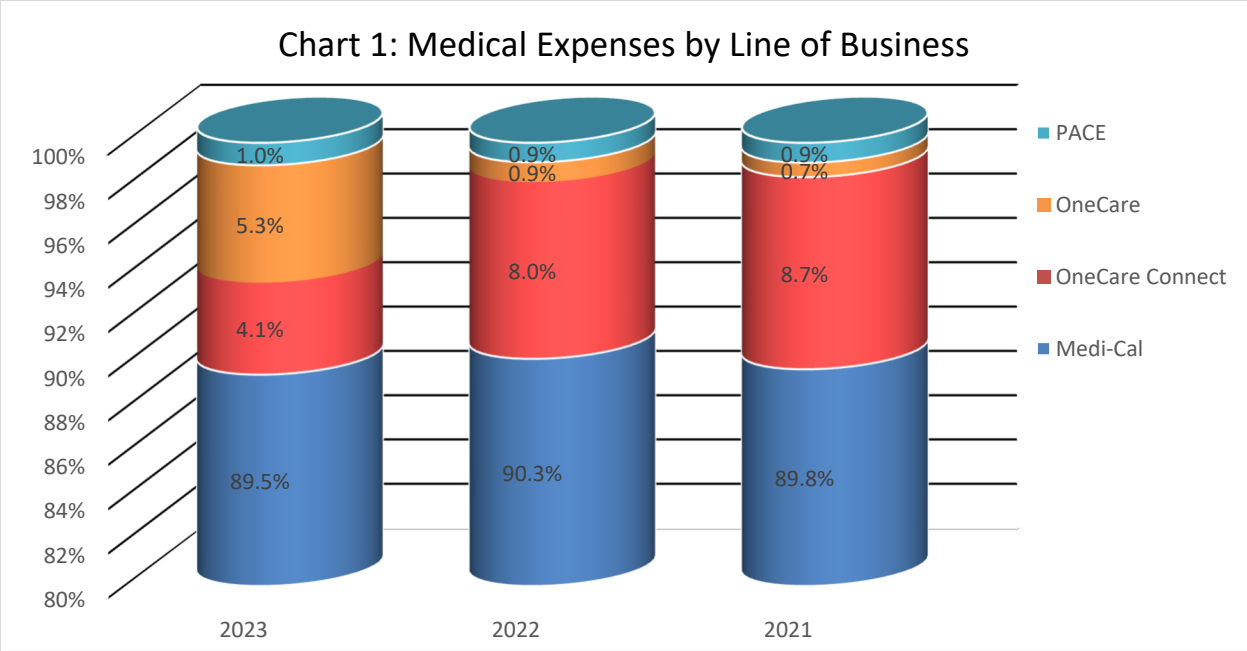
In addition to items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals decreased from $209.1 million to $146.4 million from fiscal year 2021 to fiscal year 2022. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2022 and 2021 Administrative Expenses

Total administrative expenses were $150.4 million in 2022 compared to $141.2 million in 2021. Overall administrative expenses increased by 6.6 percent or $9.3 million, primarily due to non-salary and wages expense categories. In fiscal years 2022 and 2021, CalOptima Health's administrative expenses were 3.6 percent and 3.4 percent of total operating revenues, respectively.

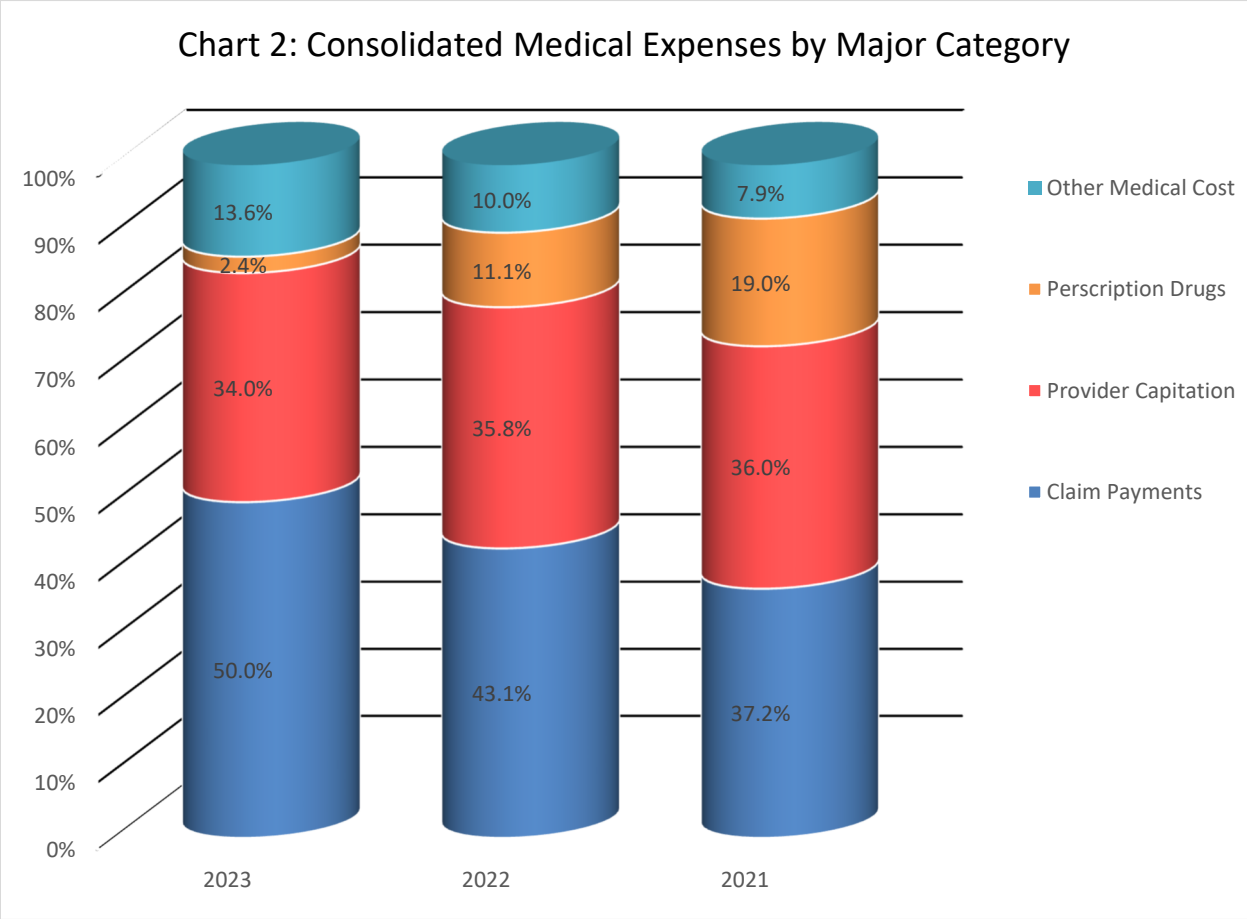
2023, 2022, and 2021 Medical Expenses by Line of Business

Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



2023, 2022, and 2021 Medical Expenses by Major Category

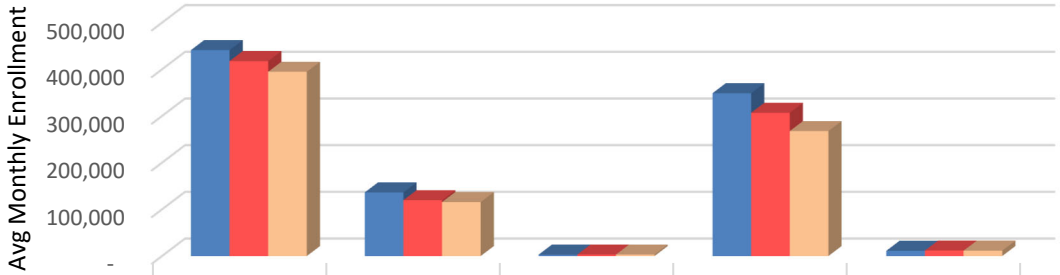
Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2023, 2022, and 2021 Enrollment

During fiscal year 2023, CalOptima Health served an average of 940,893 Medi-Cal members per month compared to an average of 859,290 members per month in 2022 and 793,023 members per month in 2021. The increase is attributed to the State's pause in Medi-Cal eligibility redetermination which began at the beginning of the COVID-19 pandemic in March 2020 and expired on May 11, 2023. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2023, 2022, and 2021.

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/ Aged	LTC	MCE	WCM
2023	441,298	136,395	3,019	348,826	11,355
2022	417,709	119,679	3,149	306,910	11,843
2021	394,819	115,711	3,158	267,700	11,634

Significant aid categories are defined as follows:

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

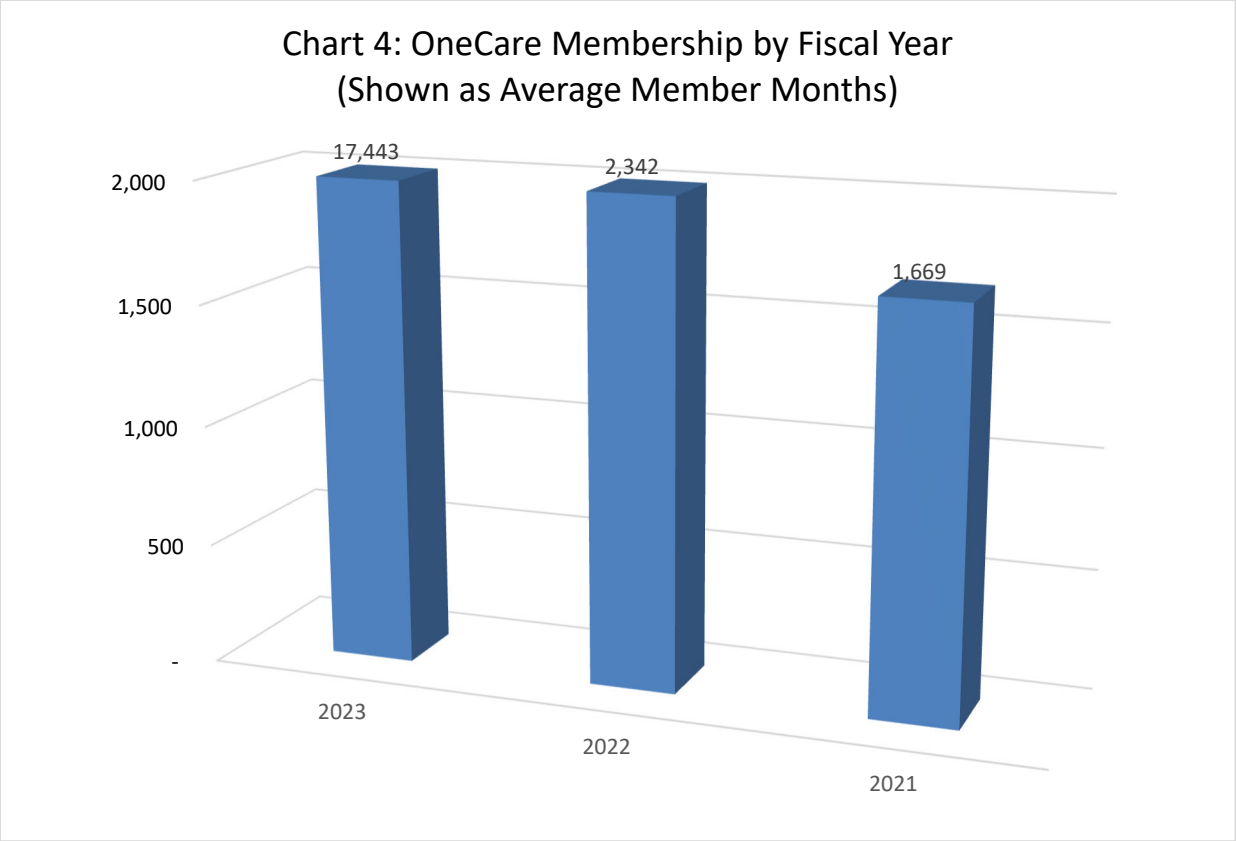
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal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

LTC includes frail elderly adults, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions that require LTC services.

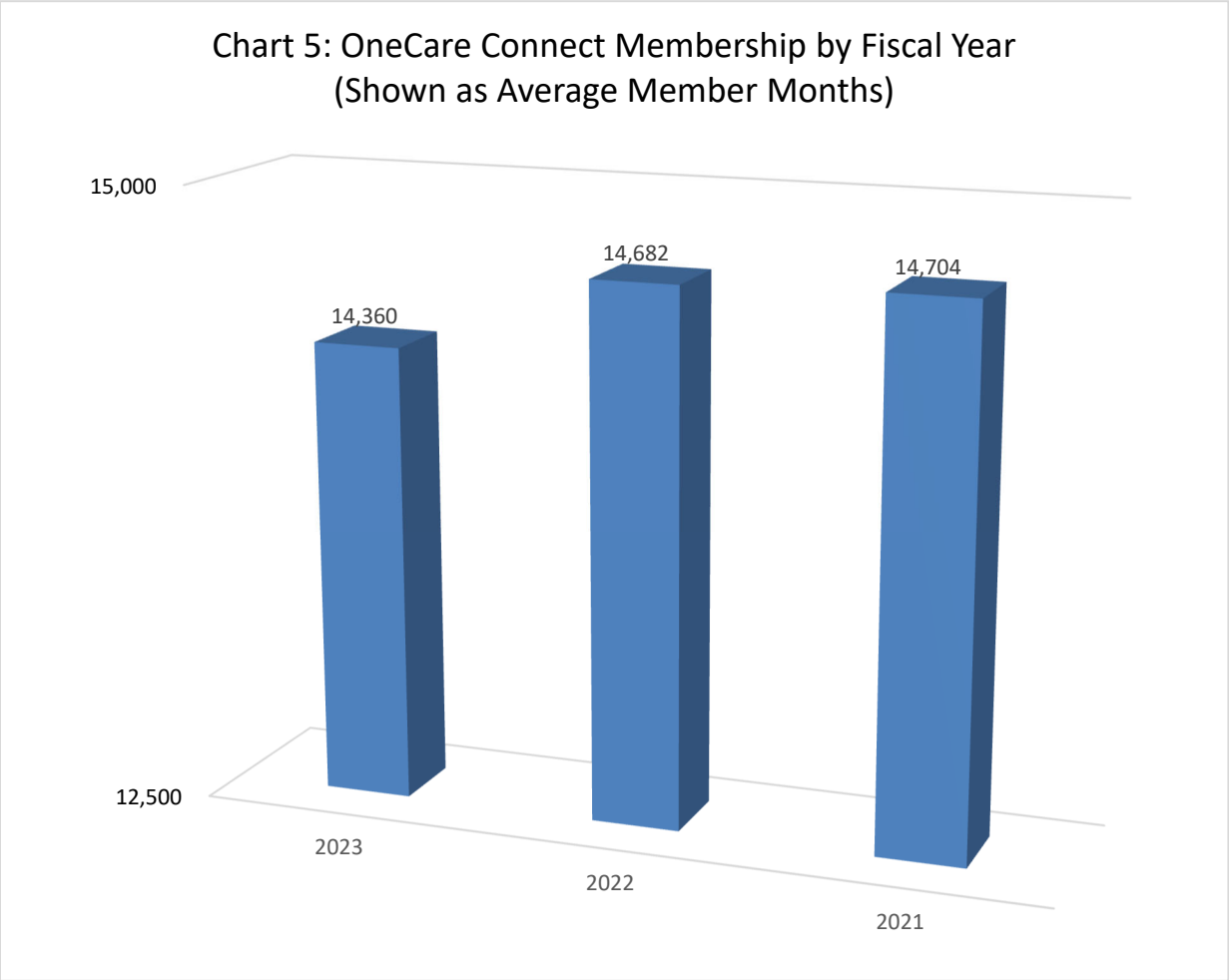
Medi-Cal Expansion (MCE) program includes adults without children, ages 19–64, who qualify based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

CalOptima Health's Whole Child Model (WCM) program includes children who are California Children's Services (CCS) eligible. These members are receiving their CCS services and non-CCS services under the WCM program.

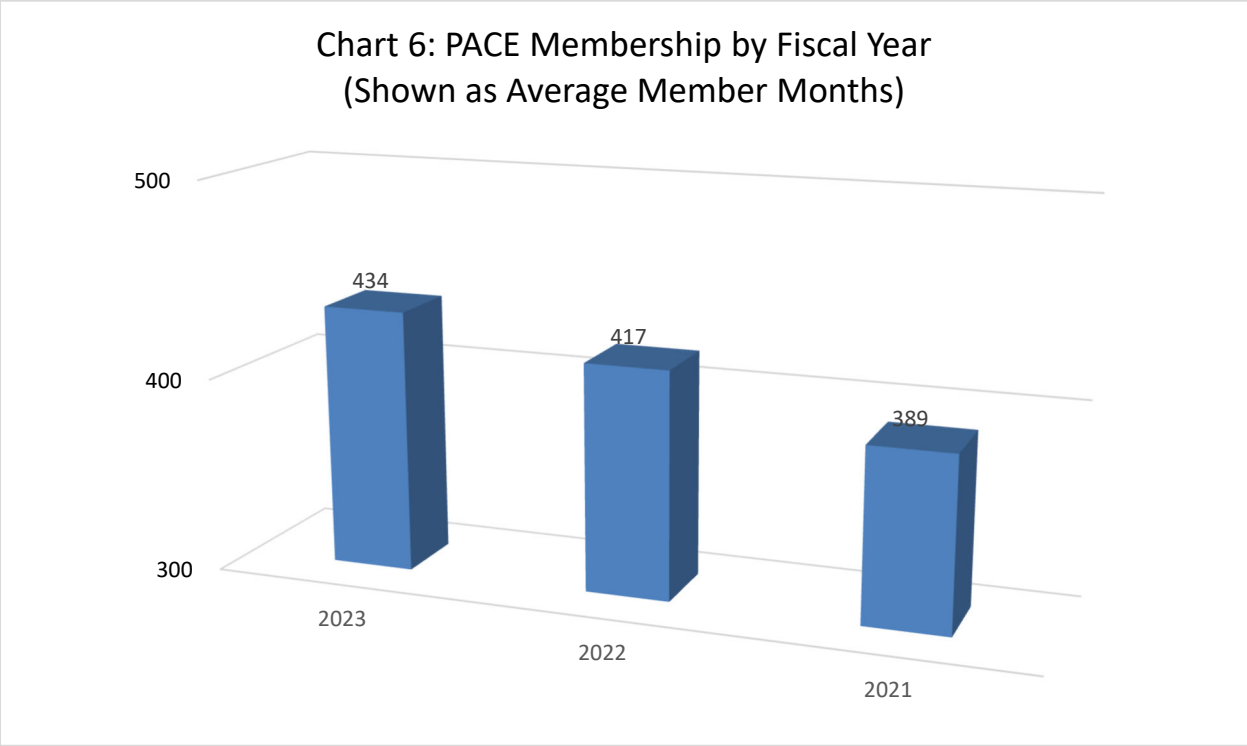
OneCare was introduced in October 2005 as a Medicare Advantage Special Needs Plan. It provides a full range of health care services to members who are eligible for both the Medicare and Medi-Cal programs (i.e., dual eligible). The average member months of 17,443, 2,342, and 1,669 for the years ended June 30, 2023, 2022, and 2021, respectively. The average member month for fiscal year 2023 was calculated using enrollment from January 2023 through June 2023 due to the transition of OneCare Connect members to OneCare beginning January 1, 2023. The chart below displays the average member months for the past three years.



CalOptima Health launched the OneCare Connect program to serve dual eligible members in Orange County in July 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 14,360, 14,682, and 14,704 for the fiscal years ended June 30, 2023, 2022, and 2021, respectively. For fiscal year 2023, the average member month was calculated with enrollment from July 2022 through December 2023 due to the transition of OneCare Connect members to OneCare on January 1, 2023. The chart below displays the average member months for the past three years.



PACE began operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them to continue living independently in the community. The average member months were 434, 417, and 389 for the fiscal years ended June 30, 2023, 2022, and 2021, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2023-24 Budget

On June 27, 2023, Governor Gavin Newsom signed the fiscal year 2023-24 state budget. The budget promotes fiscal discipline and avoids ongoing commitments to address an expected downturn in state revenue resulting from high inflation, rising interest rates and unemployment. To address an approximately $31.7 billion shortfall, the budget proposes funding shifts, reductions or pullbacks of previously approved spending, delayed spending, new revenue proposals and internal borrowing, and trigger reductions.

General Fund spending in the budget package was $225.9 billion, a decrease of $8.7 billion or 3.7 percent from fiscal year 2022-23. The budget included $37.5 billion in Total Fund spending for the Medi-Cal program. It projected an average monthly caseload of 14.2 million beneficiaries in fiscal year 2023-24, an decrease of 7.2 percent from fiscal year 2022-23. Major Medi-Cal program changes adopted in the budget include:

- Maintain investment for the California Advancing and Innovating Medi-Cal (CalAIM) Initiative;
- Renew the Managed Care Organization tax effective April 1, 2023, through December 31, 2026;

- Use MCO tax revenue to increase Medi-Cal provider rates for primary care, maternity care and non-specialty mental health services, effective January 1, 2024; and

- Expand eligibility to all income eligible adults ages 26-49 regardless of immigration status, effective no sooner than January 1, 2024.

The budget included $208.7 billion in General Fund revenues and transfers in fiscal year 2023-24, a decrease of $3.6 billion or 1.7 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were forecasted to decrease by 2.2 percent. The State is projected to end FY 2023-24 with $37.8 billion in total reserves.

DHCS Annual Audit – In December 2022, the California Department of Health Care Services (DHCS) formally engaged CalOptima Health for its annual medical program audit. The audit covered the provision of Medi-Cal services for the period of February 1, 2022 through January 31, 2023, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. As of this writing, CalOptima Health is waiting for the findings report and form request for corrective action.

DHCS Focused Audit – At the time of engagement for its annual audit scope, DHCS simultaneously engaged CalOptima Health in a focused audit for services related to transportation and behavioral health. DHCS plans to conduct this focused audit on all managed care plans; the review was not unique to CalOptima Health. Once DHCS concludes its review of all managed care plans, a comprehensive, de-identified report is anticipated to be released by second quarter 2024.

Audit by the California State Auditor – In May 2023, the California State Auditor released Report 2022-112. The audit covered certain aspects of CalOptima Health's budget, services, programs and organizational changes. As of this writing, CalOptima Health has completed its submission of the sixty (60) day update and is on track to submit the six month update in October 2023.

DHCS PACE Program Audit – In February 2023, DHCS formally engaged CalOptima Health for a routine audit of the PACE program. The audit was conducted from April 10, 2023 to April 21, 2023, with an exit conference on April 21, 2023. The audit covered grievance documentation procedures, clinical appropriateness and care planning, transportation, personnel records, subcontractor agreements, serious incident reports, onsite review of the facility, emergency preparedness, meal preparation and kitchen procedures to assess CalOptima Health's compliance with PACE regulations. The DHCS audit findings report identified eight findings for Corrective Action Required (CAR). The corrective action plan (CAP) was finalized on June 23, 2023. On July 24, 2023, DHCS accepted CalOptima Health's CAP response.

CMS Program Audit – The Centers for Medicare & Medicaid Services (CMS) engaged CalOptima Health for a virtual, full-scope program audit of the OneCare and OneCare Connect programs in early June 2021. The audit began in mid-July 2021 and ended in early August 2021. CalOptima Health received the final report from CMS in November 2021. The report included one Immediate Corrective Action Required (ICAR), eight CARs, and eleven observations. In January 2022, CMS confirmed acceptance of CalOptima Health's corrective actions for non-ICAR conditions and requested CalOptima Health to undergo an independent validation audit (IVA) by July 2022 in order to demonstrate correction of all conditions cited in the final report. CalOptima Health completed the IVA and submitted the findings report to CMS in September 2022. In January 2023, CMS requested CalOptima Health perform a revalidation audit for two findings, which were completed in May 2023 (Formulary Administration) and July 2023 (SNP-MOC). The final revalidation report was submitted to CMS on July 28, 2023. As of this writing, CalOptima Health is waiting for CMS's response to the revalidation report.

Requests for Information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Health's operations. If the reader has questions or would like additional information, please direct the requests to CalOptima Health, 505 City Parkway West, Orange, California 92868 or call (714) 347-3237.

MOSSADAMS

Report of Independent Auditors

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health (the "Organization"), which comprise the statements of net position as of June 30, 2023 and 2022, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as of June 30, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of Matter

As discussed in Note 2 to the financial statements, the Organization adopted the accounting requirements of Governmental Accounting Standards Board (GASB) Statement No. 96, *Subscription-based Information Technology Arrangements (SBITAs)* as of July 1, 2021. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

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

Moss Adams LLP

Irvine, California
September 22, 2023

Financial Statements

Back to Item

Back to Agenda

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position
June 30, 2023 and 2022

	2023	2022 (As Restated)
CURRENT ASSETS		
Cash and cash equivalents	$ 771,575,961	$ 823,489,345
Investments	1,676,736,065	1,014,460,504
Premiums due from the State of California and CMS	380,839,598	405,192,387
Prepaid expenses and other	108,144,802	94,264,454
Total current assets	2,937,296,426	2,337,406,690
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	1,940,209	44,968,923
Investments	574,611,484	566,159,456
Restricted deposit	300,000	300,051
	576,851,693	611,428,430
CAPITAL ASSETS, NET	66,189,127	66,864,042
INTANGIBLE RIGHT-TO-USE SUBSCRIPTION ASSET, net	18,018,382	260,759
Total assets	3,598,355,628	3,015,959,921
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	24,373,350	6,610,593
Other postemployment benefit	1,596,000	3,015,000
Total deferred outflows of resources	25,969,350	9,625,593
Total assets and deferred outflows of resources	$ 3,624,324,978	$ 3,025,585,514

See accompanying notes.

Back to Item

Back to Agenda

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position (Continued)
June 30, 2023 and 2022

	2023	2022 (As Restated)
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 333,993,756	$ 301,852,721
Provider capitation and withholds	125,444,022	193,214,628
Accrued reinsurance costs to providers	4,312,093	3,371,697
Subscription liability	4,556,961	79,013
Due to the State of California and CMS	1,303,463,182	1,014,382,064
Unearned revenue	61,886,332	8,049,101
	1,833,656,346	1,520,949,224
Accounts payable and other	14,540,984	10,872,861
Accrued payroll and employee benefits and other	23,332,392	19,567,540
Total current liabilities	1,871,529,722	1,551,389,625
POSTEMPLOYMENT HEALTH CARE PLAN	18,975,000	22,178,000
SUBSCRIPTION LIABILITY, net of current portion	12,173,318	140,665
NET PENSION LIABILITY	40,465,145	577,854
Total liabilities	1,943,143,185	1,574,286,144
DEFERRED INFLOWS OF RESOURCES		
Net pension	3,387,516	23,578,504
Other postemployment benefit	7,788,000	8,211,000
Total deferred inflows of resources	11,175,516	31,789,504
NET POSITION		
Net investment in capital assets	66,133,819	66,771,871
Restricted by legislative authority	107,969,096	107,345,553
Unrestricted	1,495,903,362	1,245,392,442
Total net position	1,670,006,277	1,419,509,866
Total liabilities, deferred inflows of resources, and net position	$ 3,624,324,978	$ 3,025,585,514

See accompanying notes.

Back to Item

Back to Agenda

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

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended June 30, 2023 and 2022

	2023	2022 (As Restated)
REVENUES		
Premium revenues	$ 4,239,833,266	$ 4,227,258,732
Total operating revenues	4,239,833,266	4,227,258,732
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	1,815,097,808	1,583,772,833
Provider capitation	1,275,685,079	1,284,029,592
Other medical	367,744,574	693,806,896
OneCare Connect	160,125,649	314,389,750
PACE	39,133,937	34,575,969
OneCare	204,408,932	35,273,613
Total medical expenses	3,862,195,979	3,945,848,653
Administrative expenses		
Salaries, wages, and employee benefits	129,037,210	95,941,713
Supplies, occupancy, insurance, and other	31,742,817	30,653,379
Purchased services	15,551,299	14,606,554
Depreciation and amortization	8,114,542	4,485,581
Professional fees	7,892,802	4,755,869
Total administrative expenses	192,338,670	150,443,096
Total operating expenses	4,054,534,649	4,096,291,749
OPERATING INCOME	185,298,617	130,966,983
NON-OPERATING REVENUES (LOSS)		
Net investment income (loss) and other	89,740,819	(20,319,587)
Grant expense	(25,530,071)	-
Rental income, net of related expenses	987,046	81,668
Total non-operating revenues (loss)	65,197,794	(20,237,919)
Increase in net position	250,496,411	110,729,064
NET POSITION, beginning of year	1,419,509,866	1,308,780,802
NET POSITION, end of year	$ 1,670,006,277	$ 1,419,509,866

See accompanying notes.

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

Statements of Cash Flows

Years Ended June 30, 2023 and 2022

	2023	2022 (As Restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 4,607,104,404	$ 4,568,529,851
Payments to vendors	(86,714,638)	(80,679,482)
Payments to employees	(125,545,812)	(99,272,178)
Net cash provided by operating activities	497,958,800	504,300,618
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription lease obligations	(5,414,341)	(74,871)
Purchases of capital assets	(6,499,838)	(27,839,179)
Net cash used in capital and related financing activities	(11,914,179)	(27,914,050)
CASH FLOWS (USED IN) FROM INVESTING ACTIVITIES		
Investment income received	125,584,618	9,471,378
Purchases of securities	(46,933,516,529)	(25,441,955,393)
Sales of securities	46,269,973,906	25,497,752,294
Net cash (used in) provided by investing activities	(537,958,005)	65,268,279
Net change in cash and cash equivalents	(51,913,384)	541,654,847
CASH AND CASH EQUIVALENTS, beginning of year	823,489,345	281,834,498
CASH AND CASH EQUIVALENTS, end of year	$ 771,575,961	$ 823,489,345
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 160,755,592	$ 130,966,983
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	10,719,510	6,725,892
Changes in assets and liabilities		
Premiums due from the State of California and CMS	24,352,789	22,145,381
Prepaid expenses and other	(13,880,348)	(34,727,594)
Medical claims liability	32,141,035	12,932,931
Provider capitation and withholds	(67,770,606)	48,434,840
Accrued reinsurance costs to providers	940,396	203,309
Due to the State of California and CMS	289,081,118	324,250,541
Unearned revenue	53,837,231	(5,124,803)
Accounts payable and other	4,290,685	1,823,602
Accrued payroll and employee benefits and other	3,764,852	3,350,621
Postemployment health care plan	(2,207,000)	(1,095,000)
Net pension liability	1,933,546	(5,586,086)
Net cash provided by operating activities	$ 497,958,800	$ 504,300,618
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized depreciation on investments	$ (20,441,581)	$ (25,359,620)

See accompanying notes.

Note 1 – Organization

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health, is a County-Organized Health System (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Effective August 4, 2022, Orange County Health Authority changed its dba name to CalOptima Health ("CalOptima Health" or the "Organization"). Pursuant to the California Welfare and Institutions Code, CalOptima Health was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima Health maintains an exclusive contract with the State of California (the "State"), Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 970,600 and 897,100 Medi-Cal beneficiaries for the years ended June 30, 2023 and 2022, respectively. CalOptima Health also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services (CMS). OneCare served approximately 17,700 and 2,700 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2023 and 2022, respectively.

In July 2015, CalOptima Health began offering the OneCare Connect Cal Medi Connect Plan, a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OneCare Connect served an average of 14,360 members during the period July 1, 2022 through December 31, 2022 and approximately 14,400 during the year-ended June 30, 2022. The OneCare Connect Program ended on December 31, 2022. Starting January 1, 2023, CalOptima Health transitioned all subscribers from OneCare Connect to the OneCare Plan. Enrollment in the OneCare Connect Program at December 31, 2022 was 14,385.

CalOptima Health also contracts with the California Department of Aging to provide case management of social and health care services to approximately 500 Medi-Cal eligible seniors- under the State's Multipurpose Senior Services Program (MSSP). Effective January 1, 2022, MSSP transitioned from a managed care plan benefit to a carved-out waiver benefit.

The Program of All-Inclusive Care for the Elderly (PACE) provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding and served approximately 440 members.

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

CalOptima Health is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act") to the extent incorporated by reference into CalOptima Health's contract with DHCS. As such, CalOptima Health is subject to the regulatory requirements of the Department of Managed Health Care (DMHC) under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity (TNE), which CalOptima Health exceeded as of June 30, 2023 and 2022.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima Health is a COHS plan governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. Effective for the fiscal year ended June 30, 2014, CalOptima Health began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the Board of Directors.

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

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

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

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

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

Board-designated assets and restricted cash – Board-designated assets include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 1.4 and 2 months of premium revenues and amounts designated by the Board of Directors for CalOptima Health's homeless health initiative (see Note 3). Restricted cash represents a $300,000 restricted deposit required by CalOptima Health as part of the Act (see Note 9).

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

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

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

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

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

Provider capitation and withholds – CalOptima Health has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima Health withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima Health also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $32,197,000 and $12,882,000 as of June 30, 2023 and 2022, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2023 and 2022, CalOptima Health incurred approximately $1,312,969,000 and $1,375,223,000 respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation, OneCare Connect, and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2023 and 2022, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $125,444,000 and $193,215,000, respectively.

Premium deficiency reserves – CalOptima Health performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima Health's management determined that no premium deficiency reserves were necessary as of June 30, 2023 and 2022.

Accrued compensated absences – CalOptima Health's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima Health. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

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

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

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

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

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

Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima Health in the amount of approximately $376,821,000 and $313,981,000 related to retroactive capitation rate adjustments based on receipt of new information from DHCS during the years ended June 30, 2023 and 2022, respectively.

These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima Health the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Effective with the enrollment of the Medi-Cal Expansion population per the Affordable Care Act (ACA), CalOptima Health was subject to DHCS requirements to meet the minimum 85 percent medical loss ratio (MLR) for this population. Specifically, CalOptima Health was required to expend at least 85 percent of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima Health expended less than the 85 percent requirement, CalOptima Health was required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. In March 2023, CalOptima Health was notified that CalOptima Health was not required to remit any payments to DHCS, nor will DHCS make any additional payment for fiscal year 2018. On April 5, 2023, CalOptima Health received written confirmation from DHCS that the expansion MLRs for the period of January 1, 2014, through June 30, 2016, are considered closed and final. As a result, CalOptima Health released the expansion MLR liability of approximately $135,390,000 during the current year ended June 30, 2023. The amount is recorded within premium revenues on the accompanying statements of revenues, expenses, and changes in net position.

Premium revenue and related net receivables as a percent of the totals were as follows as of June 30:

	2023		2022	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 3,809,323,101	89.8%	$ 3,802,802,931	90.0%
OneCare	214,353,873	5.1%	38,061,315	0.9%
OneCare Connect	172,148,803	4.1%	344,402,500	8.1%
PACE	44,007,489	1.0%	41,991,986	1.0%
	$ 4,239,833,266	100.0%	$ 4,227,258,732	100.0%

	2023		2022	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 355,725,299	93.4%	$ 379,774,086	93.7%
OneCare	-	0.1%	3,035,680	0.7%
OneCare Connect	22,601,354	5.9%	19,606,213	4.8%
PACE	2,512,945	0.7%	2,776,408	0.7%
	$ 380,839,598	100.0%	$ 405,192,387	100.0%

Intergovernmental transfer – CalOptima Health entered into an agreement with DHCS and Governmental Funding Entities to receive an intergovernmental transfer (IGT) through a capitation rate increase of approximately $121,159,000 and $71,747,000 during the years ended June 30, 2023 and 2022, respectively. Under the agreement, approximately $119,622,000 and $49,076,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2023 and 2022, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position or the statements of net position. CalOptima Health accounts for the IGT for CalOptima Health purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. CalOptima Health retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. Starting with rate year 2017-2018, funds expended must be tied to covered medical services provided to CalOptima Health's Medi-Cal beneficiaries. A retainer in the amount of approximately $5,698,000 and $7,744,000 as of June 30, 2023 and 2022, respectively, is included in unearned revenues in the statements of net position.

Directed Payments – DHCS implemented a new hospital Directed Payment program with CalOptima Health. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into three types: 1) Private Hospital Directed Payment Program (PHDP), 2) Public Hospital Enhanced Payment Program (EPP), and 3) Public Hospital Quality Incentive Program (QIP). Under the Directed Payment program, approximately $293,811,000 and $271,516,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2023 and 2022, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of net position.

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

The risk corridor provisions compare costs targeted in CalOptima Health's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima Health or require CalOptima Health to refund to CMS a portion of the premiums CalOptima Health received. CalOptima Health estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima Health records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of expected settlement. As of June 30, 2023 and 2022, the Part D payable balance was approximately $1,882,000 and $360,000, respectively, and is included in the due to the State of California and CMS line item on the accompanying statements of net position. As of June 30, 2023 and 2022, the Part D receivable balance was approximately $51,860,000 and $41,888,000, respectively, and is included in the prepaid expenses and other line item on the accompanying statements of net position.

Income taxes – CalOptima Health operates under the purview of the Internal Revenue Code (IRC), Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima Health is not subject to federal or state taxes on related income. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized DHCS to implement a Managed Care Organization (MCO) provider tax subject to approval by CMS. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. During fiscal year 2020, the MCO tax was extended with an effective date of January 1, 2020. Using the approved structure, each MCO's total tax liability for years ended June 30, 2023 and 2022, were calculated. CalOptima Health recognized premium tax expense of approximately $92,241,000 and $166,145,000 as a reduction of premium revenues in the statements of revenue, expenses, and changes in net position for the years ended June 30, 2023 and 2022, respectively. As the MCO tax expired on December 31, 2022, CalOptima Health did not record a MCO tax liability as of June 30, 2023. As of June 30, 2022, CalOptima Health's MCO tax liability was approximately $41,563,000, and is included in due to the State of California and CMS line item on the accompanying statements of net position.

Risk corridors – During the year ended June 30, 2021, CalOptima Health's contract with DHCS was subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, the State's fiscal year 2020-21 enacted budget included a COVID-19 (previously called Gross Medical Expense) risk corridor for the initial period of July 1, 2019 to December 31, 2021, and was extended to June 30, 2023. The State's fiscal year 2021-22 enacted budget included the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 2022, and was extended to June 30, 2023.

CalOptima Health also participates in the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridor for the period of July 1, 2019 through June 30, 2023. All risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima Health to refund premium revenues back to DHCS. CalOptima Health estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2023 and 2022, CalOptima Health recognized a liability of approximately $962,366,000 and $456,700,000, respectively, related to the risk corridors, which is included in the due to the State of California and CMS line item on the statements of net position. During the years ended June 30, 2023 and 2022, the reduction of premium revenue was approximately $575,761,000 and $228,892,000, respectively, related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position.

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

Recent accounting pronouncements – In June 2022, the GASB issued Statement No. 101, Compensated Absences (GASB 101). GASB 101 requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This statement also requires that a liability for specific types of compensated absences not be recognized until the leave is used. This statement is effective for the Organization for the year ended June 30, 2024, and management is evaluating the impact of this statement on the financial statements.

Change in accounting principle and restatement – Effective July 1, 2021, CalOptima Health implemented GASB Statement No. 96, *Subscription-based Information Technology Arrangements (SBITAs)*. This Statement provides guidance on the accounting and financial reporting for SBITAs and (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases,* as amended.

Under GASB 96, CalOptima Health determines whether the arrangement is or contains a subscription lease at inception and reassesses its determination if terms and conditions of the arrangement are changed. Intangible right-to-use subscription asset represents CalOptima Health's right to use an underlying asset for the subscription term and SBITA subscription liabilities represent CalOptima Health's obligation to make payments arising from the SBITA. SBITA subscription liabilities and their corresponding intangible right-to-use subscription asset are recorded based on the present value of subscription payments over the expected remaining subscription term. For this purpose, CalOptima Health considers only payments that are fixed and determinable at the time of commencement. The interest rate implicit in subscription contracts is typically not readily determinable. As a result, CalOptima Health has utilized the prime rate as of the adoption date for a similar term, as permitted by GASB 96. Subscription terms may include options to extend or terminate the subscription when it is reasonably certain that CalOptima Health will exercise that option.

These restatements were incorporated in CalOptima Health's financial statements and had an effect on the beginning net position of CalOptima Health. CalOptima Health recognized a SBITA subscription liability of $347,679 at July 1, 2021, due to the implementation of GASB 96; however, this amount was substantially offset by an intangible right-to-use subscription asset.

The implementation of GASB 96 had the following effect on net position as reported June 30, 2022:

Net position at June 30, 2022, as previously reported	$ 1,419,468,785
GASB 96 SBITA	41,081
Net position at June 30, 2022, as restated	$ 1,419,509,866

Reclassifications – Certain reclassifications have been made to the prior year amounts to conform to the current year presentation.

Note 3 – Cash, Cash Equivalents, and Investments

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

	2023	2022
Current assets		
Cash and cash equivalents	$ 771,575,961	$ 823,489,345
Investments	1,676,736,065	1,014,460,504
Board-designated assets and restricted cash		
Cash and cash equivalents	1,940,209	44,968,923
Investments	574,611,484	566,159,456
Restricted deposit	300,000	300,051
	$ 3,025,163,719	$ 2,449,378,279

Board-designated assets and restricted cash are available for the following purposes as of June 30:

	2023	2022
Board-designated assets and restricted cash		
Contingency reserve fund	$ 576,551,693	$ 570,491,640
Homeless Health Initiative fund	-	40,636,739
Restricted deposit with DMHC	300,000	300,051
	$ 576,851,693	$ 611,428,430

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2023 and 2022, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

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

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima Health's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima Health maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2023 and 2022, CalOptima Health's investments, including cash equivalents, had the following modified duration:

	June 30, 2023			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 652,372,690	$ 334,436,427	$ 317,936,263	$ -
U.S. Agency notes	294,565,404	-	294,565,404	-
Corporate bonds	606,478,662	151,600,486	454,878,176	-
Asset-backed securities	167,709,021	41,290,805	126,418,216	-
Mortgage-backed securities	352,525,833	24,026,927	328,498,906	-
Municipal bonds	69,679,079	26,904,673	42,774,406	-
Supranational	9,707,125	-	9,707,125	-
Commercial paper	34,824,599	34,824,599	-	-
Certificates of deposit	48,082,917	48,082,917	-	-
Cash equivalents	666,834,439	666,834,439	-	-
Cash	7,274,284	7,274,284	-	-
	2,910,054,053	$ 1,335,275,557	$ 1,574,778,496	$ -
Accrued interest receivable	15,402,218			
	$ 2,925,456,271			

	June 30, 2022			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 327,894,991	$ 36,710,632	$ 291,184,359	$ -
U.S. Agency notes	27,968,953	-	27,968,953	-
Corporate bonds	502,565,436	33,238,714	469,326,722	-
Asset-backed securities	280,622,076	-	280,622,076	-
Mortgage-backed securities	92,451,578	36,471,259	55,980,319	-
Municipal bonds	129,008,045	45,231,381	83,776,664	-
Tax exempt municipal bonds	1,208,815	-	1,208,815	-
Supranational	29,858,329	-	29,858,329	-
Commercial paper	35,969,792	5,976,862	29,992,930	-
Certificates of deposit	148,728,528	136,032,127	12,696,401	-
Cash equivalents	767,204,575	767,204,575	-	-
Cash	3,462,526	3,462,526	-	-
	2,346,943,644	$ 1,064,328,076	$ 1,282,615,568	$ -
Accrued interest receivable	4,343,416			
	$ 2,351,287,060			

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima Health portfolios are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima Health's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above as of June 30:

	2023	2022
Asset-backed securities	$ 167,709,021	$ 280,622,076
Mortgage-backed securities	352,525,833	92,451,578
	$ 520,234,854	$ 373,073,654

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

As of June 30, 2023, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 709,754,225	N/A	$ 709,754,225	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	472,401,379	N/A	472,401,379	-	-	-	-	-	-
Corporate bonds	610,956,872	A-	-	48,288,393	8,241,443	108,468,276	189,593,093	154,798,256	101,567,411
Asset-backed securities	167,997,222	AA-	-	165,939,194	2,058,028	-	-	-	-
Mortgage-backed securities	355,150,030	AAA	-	355,150,030	-	-	-	-	-
Municipal bonds	107,477,262	A-	-	66,287,078	26,428,815	10,727,556	1,007,344	1,568,179	1,458,290
Supranational	9,779,429	AAA	-	9,779,429	-	-	-	-	-
Certificates of deposit	48,838,522	A1/P1	-	48,838,522	-	-	-	-	-
Commercial paper	435,827,044	A1/P1	-	420,914,269	14,912,775	-	-	-	-
Money market mutual funds	7,274,286	AAA	-	7,274,286	-	-	-	-	-
Total	$ 2,925,456,271		$ 1,182,155,604	$ 1,122,471,201	$ 51,641,061	$ 119,195,832	$ 190,600,437	$ 156,366,435	$ 103,025,701

As of June 30, 2022, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 613,661,310	N/A	$ 613,661,310	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	112,992,781	N/A	112,992,781	-	-	-	-	-	-
Corporate bonds	504,698,493	A-	-	13,168,534	18,224,140	82,365,369	97,504,233	179,834,076	113,602,141
Asset-backed securities	280,779,086	AAA	-	268,943,920	11,835,166	-	-	-	-
Mortgage-backed securities	92,633,657	AAA	-	92,633,657	-	-	-	-	-
Municipal bonds	141,722,001	A	-	46,435,063	60,559,471	29,755,026	2,174,741	2,797,700	-
Supranational	29,898,404	AAA	-	29,898,404	-	-	-	-	-
Repurchase agreement	175,007,174	N/A	175,007,174	-	-	-	-	-	-
Certificates of deposit	153,404,888	A1/P1	-	153,404,888	-	-	-	-	-
Commercial paper	243,026,740	A1/P1	-	211,532,422	31,494,318	-	-	-	-
Money market mutual funds	3,462,526	AAA	-	3,462,526	-	-	-	-	-
Total	$ 2,351,287,060		$ 901,661,265	$ 819,479,414	$ 122,113,095	$ 112,120,395	$ 99,678,974	$ 182,631,776	$ 113,602,141

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima Health's investment in a single issuer. CalOptima Health's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10 percent may be invested in one money market mutual. As of June 30, 2023 and 2022, all holdings complied with the foregoing limitations.

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

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

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

Level 3 – Significant unobservable inputs.

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

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

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

	Investment Assets at Fair Value as of June 30, 2023			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 652,372,690	$ -	$ -	$ 652,372,690
U.S. Agency notes	-	294,565,404	-	294,565,404
Corporate bonds	-	606,478,662	-	606,478,662
Asset-backed securities	-	167,709,021	-	167,709,021
Mortgage-backed securities	-	352,525,833	-	352,525,833
Municipal bonds	-	69,679,079	-	69,679,079
Supranational	-	9,707,125	-	9,707,125
Commercial paper	-	34,824,599	-	34,824,599
Certificates of deposit	-	48,082,917	-	48,082,917
	$ 652,372,690	$ 1,583,572,640	$ -	$ 2,235,945,330

	Investment Assets at Fair Value as of June 30, 2022			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 327,894,991	$ -	$ -	$ 327,894,991
U.S. Agency notes	-	27,968,953	-	27,968,953
Corporate bonds	-	502,565,436	-	502,565,436
Asset-backed securities	-	280,622,076	-	280,622,076
Mortgage-backed securities	-	92,451,578	-	92,451,578
Municipal bonds	-	129,008,045	-	129,008,045
Tax exempt Municipal bonds	-	1,208,815	-	1,208,815
Supranational	-	29,858,329	-	29,858,329
Commercial paper	-	35,969,792	-	35,969,792
Certificates of deposit	-	148,728,528	-	148,728,528
	$ 327,894,991	$ 1,248,381,552	$ -	$ 1,576,276,543

Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2023, consisted of the following:

	June 30, 2022	Additions	Retirements	Transfers	June 30, 2023
Capital assets not being depreciated					
Land	$ 11,912,499	$ -	$ -	$ -	$ 11,912,499
Construction in progress	3,507,883	6,499,838	-	(6,964,492)	3,043,229
	15,420,382	6,499,838	-	(6,964,492)	14,955,728
Capital assets being depreciated					
Furniture and equipment	8,314,975	-	(81,528)	703,414	8,936,861
Computers and software	39,307,282	-	(7,882,165)	4,930,402	36,355,519
Leasehold improvements	5,059,409	-	(2,400)	239,717	5,296,726
Building	63,092,357	-	(300,000)	1,090,959	63,883,316
	115,774,023	-	(8,266,093)	6,964,492	114,472,422
Less: accumulated depreciation for					
Furniture and equipment	6,909,422	523,445	(81,528)	-	7,351,339
Computers and software	33,589,790	4,070,843	(7,868,331)	-	29,792,302
Leasehold improvements	5,017,129	37,220	(2,400)	-	5,051,949
Building	18,814,022	2,529,411	(300,000)	-	21,043,433
	64,330,363	7,160,919	(8,252,259)	-	63,239,023
Total depreciable assets, net	51,443,660	(7,160,919)	(13,834)	6,964,492	51,233,399
Capital assets, net	$ 66,864,042	$ (661,081)	$ (13,834)	$ -	$ 66,189,127

Capital asset activity during the year ended June 30, 2022, consisted of the following:

	June 30, 2021	Additions	Retirements	Transfers	June 30, 2022
Capital assets not being depreciated					
Land	$ 5,876,002	$ 6,036,497	$ -	$ -	$ 11,912,499
Construction in progress	267,512	5,207,679	-	(1,967,308)	3,507,883
	6,143,514	11,244,176	-	(1,967,308)	15,420,382
Capital assets being depreciated					
Furniture and equipment	8,074,334	-	-	240,641	8,314,975
Computers and software	38,173,040	-	-	1,134,242	39,307,282
Leasehold improvements	5,063,118	-	-	(3,709)	5,059,409
Building	45,901,220	16,595,003	-	596,134	63,092,357
	97,211,712	16,595,003	-	1,967,308	115,774,023
Less: accumulated depreciation for					
Furniture and equipment	6,372,964	536,458	-	-	6,909,422
Computers and software	29,618,855	3,970,935	-	-	33,589,790
Leasehold improvements	4,950,031	67,098	-	-	5,017,129
Building	16,685,495	2,128,527	-	-	18,814,022
	57,627,345	6,703,018	-	-	64,330,363
Total depreciable assets, net	39,584,367	9,891,985	-	1,967,308	51,443,660
Capital assets, net	$ 45,727,881	$ 21,136,161	$ -	$ -	$ 66,864,042

The Organization recognized depreciation expense of approximately $4,515,000 and $4,486,000 during the years ended June 30, 2023 and 2022, respectively. During the years ended June 30, 2023 and 2022, depreciation expense of approximately $108,000 and $92,000, respectively, was included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following as of June 30:

	2023	2022
Claims payable or pending approval	$ 52,909,889	$ 48,231,910
Provisions for IBNR claims	281,083,867	253,620,811
	$ 333,993,756	$ 301,852,721

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima Health estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability for the years ended June 30:

	2023	2022
Beginning balance	$ 301,852,721	$ 288,919,790
Incurred		
Current	2,099,911,537	2,231,310,673
Prior	(65,796,666)	(88,742,120)
	2,034,114,871	2,142,568,553
Paid		
Current	1,765,917,781	1,929,457,952
Prior	236,056,055	200,177,670
	2,001,973,836	2,129,635,622
Ending balance	$ 333,993,756	$ 301,852,721

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior year incurred of approximately $66,797,000 and $88,742,000 for the fiscal years ended June 30, 2023 and 2022, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in the due to the State of California and CMS line item represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments and the remaining overpayments not yet recouped are included within the due to the State of California and CMS line item on the statements of net position.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima Health's defined benefit pension plan, the CalPERS Plan, provides retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members and/or beneficiaries. The CalPERS Plan is part of the public agency portion of CalPERS, an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the State. Optional contract provisions are available through the Public Employees' Retirement Law. CalOptima Health selects optional benefit provisions by contracting with CalPERS and adopting those benefits through Board of Directors approval (See "Benefits Provided" below for more details). CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and/or beneficiaries. Pension benefits are based on plan members' years of service, age and final compensation (three-year average) at the time of retirement. Members with five years of total service are eligible to retire at age 50 (Classic Member) or age 52 (New Member) with statutorily reduced benefits. All members are eligible for non-duty disability benefits if they have at least five years of service credit. Optional provisions elected by CalOptima Health include a 3% Cost of Living Allowance (Section 21335), 1959 Survivor Benefit Level 3 (Section 21573), $5,000 Retired Death Benefit (Section 21623.5), a 3-Year Final Compensation Period (Section 20037), Pre-Retirement Death Benefits to Continue After Remarriage of Survivor (Section 21551), as well as service credit purchase options for military and peace corps service (Section 21024 and 21023.5, respectively).

The CalPERS Plan's provisions and benefits in effect as of June 30, 2023, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2 % at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	Monthly for life	Monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	1.092%-2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	7.75%
Required employer contribution rates	8.41%	8.41%

The following is a summary of plan participants:

	June 30, 2023	June 30, 2022
Active employees	1,583	1,445
Retirees and beneficiaries		
Receiving benefits	220	192
Deferred retirement benefits		
Terminated employees	1,222	1,136
Surviving spouses	5	3
Beneficiaries	1	0

Contributions – Section 20814(c) of the California Public Employees' Retirement Law (PERL) requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The active employee contribution rate is 7.75 percent (PEPRA New Members) and 7.0 percent (Classic Members) of annual pay for the years ended June 30, 2023 and 2022, respectively. The employer's contribution rate is 8.41 percent and 8.52 percent of annual payroll for the years ended June 30, 2023 and 2022, respectively.

CalOptima Health's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2022 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2021 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2022 and June 30, 2021:

Valuation date	June 30, 2021
Measurement date	June 30, 2022
Actuarial cost method	Entry Age Normal
Actuarial assumptions	
Discount rate	6.90%
Inflation	2.30%
Salary increases	Varies by Entry Age and Service
Investment rate of return	7.0% Net of Pension Plan Investment and Administrative Expenses; Includes Inflation
Mortality rate table	Derived using CalPERS' Membership data for all funds
Post-retirement benefit increase	Floor on Purchasing Power applies, 2.30% thereafter

The mortality table used was developed based on CalPERS-specific data. The probabilities of mortality are based on the 2021 CalPERS Experience Study for the period from 2001 to 2019. Pre-retirement and Post-retirement mortality rates include generational mortality improvement using 80% of Scale MP-2020 published by the Society of Actuaries. For more details on this table, please refer to the CalPERS Experience Study and Review of Actuarial Assumptions report from November 2021 that can be found on the CalPERS website.

Changes in the net pension liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2022	$ 240,018,505	$ 239,440,651	$ 577,854
Changes during the year			
Service cost	17,958,280	-	17,958,280
Interest on the total pension liability	17,450,590	-	17,450,590
Differences between expected and actual experience	8,006,529	-	8,006,529
	(1,930,719)	-	(1,930,719)
Contributions from the employer	-	11,688,269	(11,688,269)
Contributions from employees	-	8,634,939	(8,634,939)
Net investment income	-	(18,576,662)	18,576,662
Benefit payments, including refunds of employee contributions	-	(149,157)	149,157
Administrative expenses	(4,332,714)	(4,332,714)	-
Net changes during the year	37,151,966	(2,735,325)	39,887,291
Balance at June 30, 2023	$ 277,170,471	$ 236,705,326	$ 40,465,145

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2021	$ 212,182,252	$ 181,562,247	$ 30,620,005
Changes during the year			
Service cost	16,033,791	-	16,033,791
Interest on the total pension liability	15,591,711	-	15,591,711
Differences between expected and actual experience	(477,252)	-	(477,252)
Contributions from the employer	-	10,742,812	(10,742,812)
Contributions from employees	-	7,981,938	(7,981,938)
Net investment income	-	42,647,021	(42,647,021)
Benefit payments, including refunds of employee contributions	(3,311,997)	(3,311,997)	-
Administrative expenses	-	(181,370)	181,370
Net changes during the year	27,836,253	57,878,404	(30,042,151)
Balance at June 30, 2022	$ 240,018,505	$ 239,440,651	$ 577,854

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 6.90 percent. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the next 20 years using a building-block approach. The expected rate of return was then adjusted to account for assumed administrative expenses of 10 Basis points.

The table below reflects long-term expected real rate of return by asset class.

Asset Class	Assumed Return Allocation	Real Return[(1)]
Global Equity - Cap-weighted	30.0%	4.54%
Global Equity - Non-Cap-weighted	12.0%	3.84%
Private Equity	13.0%	7.28%
Treasury	5.0%	0.27%
Mortgage-backed Securities	5.0%	0.50%
Investment Grade Corporates	10.0%	1.56%
High Yield	5.0%	2.27%
Emerging Market Debt	5.0%	2.48%
Private Debt	5.0%	3.57%
Real Assets	15.0%	3.21%
Leverage	-5.0%	-0.59%

(1) An expected inflation of 2.3% was used for this period

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2023		
	Discount Rate -1% 5.90%	Current Discount Rate 6.90%	Discount Rate +1% 7.9%
Net pension liability	$ 88,612,198	$ 40,465,145	$ 1,732,263

	June 30, 2022		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 40,373,662	$ 577,854	$ (31,585,618)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately $16,255,000 and $6,790,000 for the years ended June 30, 2023 and 2022, respectively. As of June 30, 2023 and 2022, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 2,375,580	$ -
Net differences between projected and actual earnings on plan investments	12,718,340	-
Changes in assumptions	7,732,138	(1,202,155)
Differences between expected and actual experiences	1,547,292	(2,185,361)
	$ 24,373,350	$ (3,387,516)

	June 30, 2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,931,845	$ -
Net differences between projected and actual earnings on plan investments	-	(20,982,636)
Changes in assumptions	2,325,077	(1,909,305)
Differences between expected and actual experiences	2,353,671	(686,563)
	$ 6,610,593	$ (23,578,504)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2023. The differences reported as deferred outflows and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

	Deferred Outflows of Resources
Years Ending June 30,	
2023	$ 4,056,867
2024	2,931,879
2025	2,302,871
2026	7,953,241
2027	898,026
Thereafter	467,370
	$ 18,610,254

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima Health sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima Health may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2023 and 2022, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima Health established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima Health makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2023 and 2022, CalOptima Health contributed approximately $5,777,000 and $4,743,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima sponsors and administers a single-employer defined-benefit postemployment healthcare plan (the Plan) to provide medical, dental, and vision insurance benefits to eligible retired employees and their beneficiaries. Plan members receiving benefits contribute at the same rate as current active employees. Benefit provisions are established and may be amended by the CalOptima Board of Directors.

Effective January 1, 2004, CalOptima terminated postemployment healthcare benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan. Surviving spouses are also eligible for this benefit.

During the year ended June 30, 2006, CalOptima Health modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima Health would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima Health.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the CalOptima's plan (OPEB Plan) and additions to/deductions from the OPEB Plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement date	June 30, 2022
Measurement period	July 1, 2021 - June 30, 2022
Valuation date	January 1, 2022

Covered employees – The following numbers of participants were covered by the benefit terms as of June 30:

	2023	2022
Inactives currently receiving benefits	76	72
Active employees	65	73
Inactives entitled to but not yet receiving benefits	3	-
Total	144	145

Contributions – The contribution requirements of plan members and CalOptima Health are established and may be amended by the Board of Directors. CalOptima Health's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima Health contributed $528,000, which related to implied subsidies, for the year ended June 30, 2023. CalOptima Health contributed $529,000, including $464,000 in premium payments for retirees and $65,000 for implied subsidies, for the year ended June 30, 2022. The most recent actuarial report for the postemployment health care plan was June 30, 2022. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $18,975,000.

Actuarial assumptions – CalOptima Health's total postemployment retirement liability was measured as of June 30, 2022, and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated January 1, 2022, that was rolled forward to determine the June 30, 2022 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary increases	2.75% per annum, in aggregate
Medical trend	Non-Medicare – 6.5% for 2023, decreasing to an ultimate rate of 3.75% in 2076 Medicare (Non-Kaiser) – 5.65% for 2023, decreasing to an ultimate rate of 3.75% in 2076 Medicare (Kaiser) – 4.6% for 2023, decreasing to an ultimate rate of 3.75% in 2076
Discount rate	3.54% at June 30, 2022, Bond Buyer 20 Index 2.16% at June 30, 2021, Bond Buyer 20 Index
Mortality, retirement	CalPERS 2000-2019 Experience Study Post-retirement mortality projected fully generational with Scale MP-2021
General inflation	2.50% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 3.54 percent for June 30, 2022. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

Changes in the net OPEB liability – Changes in the net OPEB liability were as follows:

Balance at June 30, 2022	$ 22,178,000
Changes for the year	
Service cost	668,000
Interest	487,000
Assumption changes	(3,829,000)
Net changes	(3,203,000)
Balance at June 30, 2023	$ 18,975,000

Balance at June 30, 2021	$ 31,610,000
Changes for the year	
Service cost	1,149,000
Interest	718,000
Actual vs. expected experience	(6,241,000)
Assumption changes	(4,514,000)
Benefit payments	(544,000)
Net changes	(9,432,000)
Balance at June 30, 2022	$ 22,178,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	1% Decrease (2.54%)	Current Rate (3.54%)	1% Increase (4.54%)
Total OPEB liability	$ 21,645,000	$ 18,975,000	$ 16,764,000

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 16,282,000	$ 18,975,000	$ 22,325,000

For the years ended June 30, 2023 and 2022, respectively CalOptima Health recognized a reduction to OPEB expense of approximately $1,679,000 and $566,000. As of June 30, 2023 and 2022, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 2,867,000
Changes in assumptions	1,068,000	4,921,000
Employer contributions made subsequent to measurement date	528,000	-
Total	$ 1,596,000	$ 7,788,000

	June 30, 2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 4,822,000
Changes in assumptions	2,486,000	3,389,000
Employer contributions made subsequent to measurement date	529,000	-
Total	$ 3,015,000	$ 8,211,000

The $528,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2023 measurement date will be recognized as a reduction of the total post-employment retirement liability during the fiscal year ended June 30, 2023.

Other amounts reported as deferred inflows of resources related to OPEB will be recognized as expense as follows:

	Deferred Inflows of Resources
Years Ending June 30,	
2024	$ (2,821,000)
2025	(3,016,000)
2026	(883,000)
	$ (6,720,000)

The required schedule of changes in total OPEB liability immediately following the notes to the financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima Health became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima Health is required to maintain and meet a minimum level of TNE as of June 30, 2023 and 2022, of $107,969,096 and $107,345,553, respectively. As of June 30, 2023 and 2022, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima Health maintain a restricted deposit in the amount of $300,000. CalOptima Health met this requirement as of June 30, 2023 and 2022.

Note 10 – Lease Commitments

CalOptima Health leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Years Ending June 30,	
2024	$ 611,457
2025	631,929
2026	653,016
2027	710,210
2028	768,055
Thereafter	2,871,040
	$ 6,245,706

Rental expense under operating leases was approximately $713,000 and $592,000 for the years ended June 30, 2023 and 2022, respectively.

Note 11 – Contingencies

Litigation – CalOptima Health is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima Health's financial position or results of operations.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima Health is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 12 –Subscription-based Information Technology Arrangements

CalOptima Health has several subscription contracts that expire at various dates through 2027 with some having certain renewal options. For those contracts where renewal options are reasonably certain to be exercised, CalOptima Health recognizes renewal option periods in the determinations of its intangible right-to-use subscription assets and SBITA subscription liabilities. CalOptima Health uses various rates ranging from 3.25 percent to 8 percent to determine the present value of the SBITA subscription liabilities. The amortization on the intangible subscription asset amounted to approximately $3,600,000 and $80,000 during the years ended June 30, 2023 and 2022, respectively and is included in depreciation and amortization on the statement of revenues, expenses and changes in net position. As of June 30, 2023 and June 30, 2022 CalOptima Health recognized approximately $18,018,000 and $261,000, respectively, in intangible right-to-use subscription assets which is comprised of the intangible right-to-use subscription asset cost of approximately $21,733,000 and $341,000, respectively, less accumulated amortization of approximately $3,714,000 and $80,000, respectively. As of June 30, 2023 and June 30, 2022 CalOptima Health recognized approximately $16,730,000 and $220,000, respectively, in SBITA subscription liabilities.

The future subscription payments under SBITA agreements as of June 30, 2023 are as follows:

	Subscriptions		
	Principal	Interest	Total
Years Ending June 30,			
2024	$ 5,282,158	$ 925,959	$ 6,208,117
2025	5,381,104	632,979	6,014,083
2026	3,895,440	390,546	4,285,986
2027	4,159,153	126,834	4,285,987
Total undiscounted cash flows	18,717,855	2,076,318	20,794,173
Less: present value discount			4,063,894
Total subscription liabilities			$ 16,730,279

Supplementary Information

Back to Item

Back to Agenda

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

Schedule of Changes in Net Pension Liability and Related Ratios

Years Ended June 30

	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total pension liability									
Service cost	$ 17,958,280	$ 16,033,791	$ 15,223,385	$ 14,303,164	$ 13,491,596	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	17,450,590	15,591,711	13,770,107	12,107,314	10,431,464	9,136,725	7,702,198	6,620,025	5,661,111
Differences between expected and actual experience	8,006,529	(477,252)	(405,662)	1,904,567	2,812,748	632,642	102,384	1,444,808	-
Changes in assumptions	(1,930,719)	-	-	-	(4,737,905)	9,163,547	-	(1,963,270)	-
Benefit payments, including refunds of employee contributions	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net change in total pension liability	37,151,966	27,836,253	25,010,908	25,473,833	19,249,204	29,983,353	15,965,410	12,788,080	10,798,852
Total pension liability – beginning	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,464	72,912,613
Total pension liability – ending	277,170,471	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,465
Plan fiduciary net position									
Contributions – employer	$11,688,269	10,742,812	9,608,656	8,661,466	7,588,200	5,234,580	3,787,544	3,033,171	3,119,804
Contributions – employee	8,634,939	7,981,938	7,518,241	6,853,391	6,213,420	5,793,911	4,951,820	4,142,126	3,385,296
Net investment income	(18,576,662)	42,647,021	8,189,430	9,377,613	10,225,467	11,496,425	498,498	1,913,380	12,062,654
Benefit payments, including refunds of employee contributions	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other changes in fiduciary net position	(149,157)	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	(2,735,325)	57,878,404	21,513,776	21,953,024	20,747,960	20,313,296	7,071,456	7,310,765	17,241,390
Plan fiduciary net position – beginning	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970	65,410,580
Plan fiduciary net position – ending	236,705,326	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970
Plan net pension liability – ending	$ 40,465,145	$ 577,854	$ 30,620,005	$ 27,122,873	$ 23,602,064	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	85.40%	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 109,836,572	$ 103,913,095	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan net pension liability as a percentage of covered-employee payroll	36.84%	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

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

Schedule of Plan Contributions

Years Ended June 30

	2023	2022	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 11,688,269	$ 10,742,812	$ 9,608,656	$ 8,661,466	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(11,688,269)	(10,742,812)	(9,608,656)	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 109,836,572	$ 103,913,095	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contributions as a percentage of covered-employee payroll	10.64%	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

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

Schedule of Changes in Total OPEB Liability and Related Ratios

Periods Ended June 30

	2022-2023 (Measurement Period 2021–2022)	2021-2022 (Measurement Period 2020–2021)	2020-2021 (Measurement Period 2019–2020)	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)	2017–2018 (Measurement Period 2016–2017)
Changes in total OPEB liability						
Service cost	$ 668,000	$ 1,149,000	$ 811,000	$ 832,000	$ 867,000	$ 1,012,000
Interest	487,000	718,000	922,000	977,000	900,000	770,000
Actual vs. expected experience	-	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	(3,829,000)	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(529,000)	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(3,203,000)	(9,432,000)	5,786,000	1,119,000	140,000	(1,713,000)
Total OPEB liability (beginning of year)	22,178,000	31,610,000	25,824,000	24,705,000	24,565,000	26,278,000
Total OPEB liability (end of year)	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Total OPEB liability	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Covered employee payroll	8,864,000	9,126,000	8,513,000	8,353,000	8,150,000	9,135,000
Total OPEB liability as a percentage of covered employee payroll	214.1%	243.0%	371.3%	309.2%	303.1%	268.9%

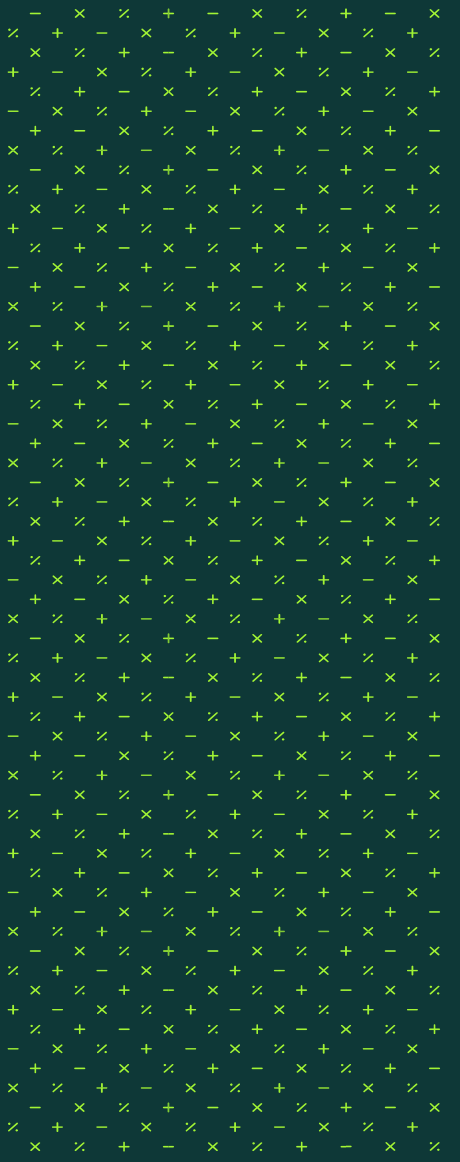
MOSSADAMS

CalOptima Health

2023 AUDIT RESULTS

Discussion with the Board of Directors (the “Board”)

October 5, 2023

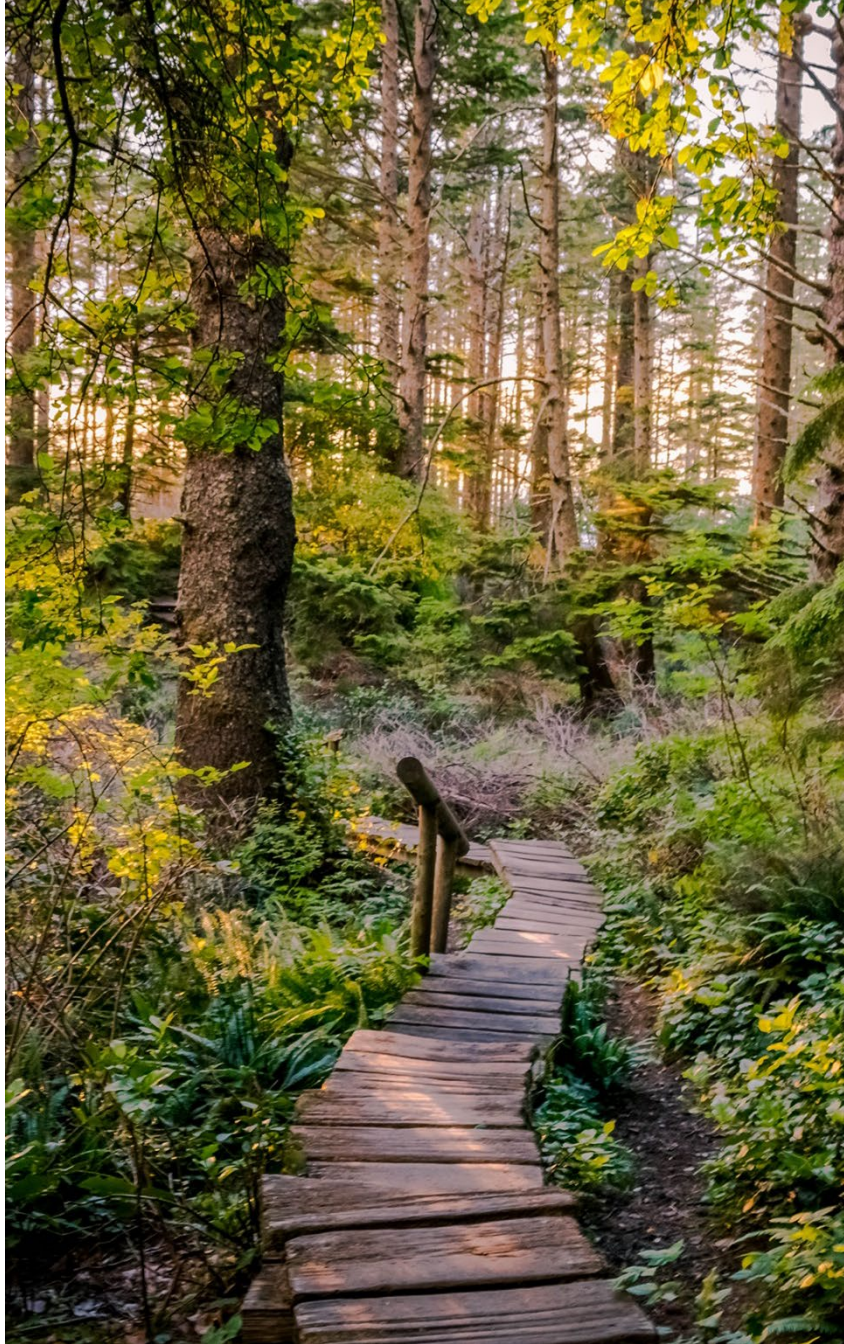


Back to Item

Back to Agenda

Agenda

1. Scope of Services
2. Summary of Audit Process
3. Areas of Audit Emphasis
4. Matters to Be Communicated to the Governing Body
5. Your Service Team



Back to Item

Back to Agenda

Scope of Services

We have performed the following services for CalOptima Health:

Attest Services

- Annual financial statement audit as of and for the year ended June 30, 2023.

Nonattest Services

- Assisted management with drafting the financial statements, excluding Management's Discussion and Analysis, as of and for the year ended June 30, 2023.
- Assisted in the completion of the Auditee portion of the Data Collection Form for the single audit as of and for the year ended June 30, 2023.

Back to Item

Summary of Audit Process

- Our audit was generally performed in accordance with our initial plan. When the results of a planned audit procedure did not provide sufficient evidence or our original plan was based on an incorrect understanding of a transaction, process, or accounting policy of the entity, we made the necessary adjustments to our audit plan to incorporate the procedures necessary to support our opinion on the financial statements.

- We have completed our testing of all significant account balances and classes of transactions.

- We issued our independent auditor's report and have communicated required internal control related matters dated September 22, 2023.

Back to Item

Areas of Audit Emphasis

During the audit, we identified the following:

Significant Risks	Procedures
Medical claims liability and claims expense	• Tested the internal controls for claims payments and provider capitation systems • Tested the data used by the actuary to estimate the claims liability and reviewed the experience and qualifications of the actuary • Performed a retrospective review of the prior year's claims liability
Capitation revenue and receivables	• Developed independent expectations of revenue using membership data and rates • Obtained an understanding of management's reserve methodology and validated key inputs through our audit procedures • Verified subsequent receipt of cash and other substantive procedures
Amounts due to the State of California or DHCS	• Tested the provider capitation and other accrual calculations and agreed amounts accrued to subsequent payments • Obtained an understanding of the nature of the amounts payable to the State of California • Tested inputs into the estimates used to calculate the amounts due

Back to Item

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Back to Item

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) as well as *Government Auditing Standards*, issued by the Comptroller General of the United States. As part of an audit conducted in accordance with these auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

Back to Item

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.

Back to Item

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Significant management estimates impacted the financial statements including the following: **fair value of investments, capital asset lives, actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

Moss Adams Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 3 – Cash, Cash Equivalents, and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Unusual Transactions

MOSS ADAMS COMMENTS

No significant unusual transactions were identified during our audit of the entity's financial statements.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Difficulties Encountered During the Audit

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor, or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

MOSS ADAMS COMMENTS

No significant difficulties were encountered during our audit of the entity's financial statements.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Disagreements With Management

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

MOSS ADAMS COMMENTS

There were no disagreements with management.

Back to Item

Back to Agenda

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Circumstances that affect the form and content of the auditor's report

MOSS ADAMS COMMENTS

There were no circumstances that affected the form and content of the auditor’s report.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process

MOSS ADAMS COMMENTS

There were no other findings or issues arising from the audit to report.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Uncorrected Misstatements

Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the year ended June 30, 2023 could potentially cause future-period financial statements to be materially misstated.

MOSS ADAMS COMMENTS

No uncorrected misstatements were identified.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Material, Corrected Misstatements

Material, corrected misstatements that were brought to the attention of management as a result of audit procedures.

MOSS ADAMS COMMENTS

No material misstatements were identified as a result of our audit.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Representations requested of management

We requested certain representations from management that are included in the management representation letter dated September 22, 2023.

MOSS ADAMS COMMENTS

A copy of the management representation letter is available upon request.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Management's consultation with other accountants

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

MOSS ADAMS COMMENTS

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant issues arising from the audit that were discussed, or the subject of correspondence with management

MOSS ADAMS COMMENTS

No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

AU-C 240, *Consideration of Fraud in a Financial Statement Audit*

AU-C 250, *Consideration of Laws and Regulations in an Audit of Financial Statements*

AU-C 265, *Communicating Internal Control Related Matters Identified in an Audit*

AU-C 550, *Related Parties*

AU-C 560, *Subsequent Events and Subsequently Discovered Facts*

AU-C 570, *The Auditor's Consideration of An Entity's Ability to Continue as a Going Concern*

AU-C 600, *Audits of Group Financial Statements (Including the Work of Component Auditors)*

MOSS ADAMS COMMENTS

Nothing to note.

- There were no material weaknesses noted and no significant deficiencies to communicate.

Back to Item

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

AU-C 701, *Communicating Key Audit Matters in the Independent Auditor's Report*

AU-C 705, *Modifications to the Opinion in the Independent Auditor's Report*

AU-C 706, *Emphasis-of-Matter Paragraphs and Other-Matter Paragraphs in the Independent Auditor's Report*

AU-C 720, *The Auditor's Responsibilities Relating to Other Information Included in Annual Reports*

AU-C 730, *Required Supplementary Information*

AU-C 930, *Interim Financial Information*

AU-C 935, *Compliance Audits*

MOSS ADAMS COMMENTS

Nothing to note.

Back to Item

Your Service Team

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Engagement Reviewer

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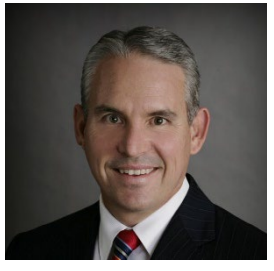

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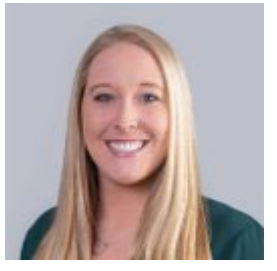

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Back to Item

THANK YOU

Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
10. Ratify Actions Related to Purchasing the Garden Grove Street Medicine Support Center

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
1. Ratify expenditure of $39,836.50 for the overage in the final purchase price above the Board-authorized amount of $8 million for acquisition of real property located at 7900 Garden Grove Boulevard, Garden Grove, California.

Background
On March 17, 2022, CalOptima Health's Board of Directors (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of Street Medicine. On May 5, 2022, CalOptima Health's Board approved the Street Medicine scope of work (SOW). On November 3, 2022, CalOptima Health's Board authorized the Chief Executive Officer to execute a contract with Healthcare in Action to provide street canvasing-based medical services. The Street Medicine pilot program launched in Garden Grove on April 1, 2023.

In order to design a comprehensive Street Medicine Program, on May 4, 2023, the Board authorized staff to develop a proposal to include a Street Medicine Support Center and locate a property in the City of Garden Grove (City) for the location of the pilot program. Staff entered into a Purchase and Sale Agreement on May 26, 2023. On June 27, 2023, the City unanimously supported a Memorandum of Understanding (MOU) between the City and CalOptima Health to partner and support the establishment of a Street Medicine Support Center. On June 29, 2023, CalOptima approved said MOU with the City and entered into the escrow period to purchase the Street Medicine Support Center.

Discussion
CalOptima Health closed escrow on September 25, 2023, and acquired the real property located at 7900 Garden Grove Boulevard, Garden Grove, California, with plans to repurpose the property's use as the initial Street Medicine Support Center. The Street Medicine Support Center will feature 52 private guest rooms that will serve 52 members. Each guest room will be furnished and will include a kitchenette and a bathroom. The Street Medicine Support Center will also include staff administrative offices, laundry facilities, and an outdoor open space.

The Street Medicine Support Center will offer priority placement to older adults, families, and veterans of the Street Medicine Program. Participants will receive three-meals a day, and on-site security will be provided 24 hours a day. While there is no limit of stay, it is estimated that individuals will remain for approximately 90 days.

Back to Agenda

In September, the Board unanimously voted to approve the acquisition of the property at 7900 Garden Grove Boulevard, Garden Grove, California for a purchase price of up to $8 million. Upon closing, the seller of the property met the terms of the purchase and sale agreement to receive the full exclusive negotiating fee of $120,000. The total final purchase price was $8,039,836.50. The final purchase price exceeded the Board-authorized amount by $39,836.50. Staff is seeking ratification of this overage amount.

Fiscal Impact
An appropriation of $39,836.50 in undesignated reserves will fund this action.

Rationale for Recommendation
The recommended actions will allow CalOptima Health to develop the Street Medicine Support Center according to its mission and vision.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Final Draft Buyer Settlement Statement

/s/ Michael Hunn *09/28/2023*
Authorized Signature **Date**

Back to Agenda

FIDELITY NATIONAL TITLE COMPANY

3237 East Guasti Road, Suite 105, Ontario, CA 91761
Phone: (909) 569-0226 Fax: (800) 507-0841

Buyers/Borrowers Settlement Statement
Estimated

Escrow No: 30094459 - 012 JR **Close Date:** 09/25/2023 **Proration Date:** 09/25/2023 **Disbursement Date:**

Buyer(s)/Borrower(s): Orange County Health Authority, a public agency
Seller(s): Haven Exchange, Exchange#: 6964, as Qualified Intermediary fbo LVT, Inc., a California corporation

Property: 7900 Garden Grove Boulevard
Garden Grove, CA 92841

Description	Debit	Credit
TOTAL CONSIDERATION:		
Total Consideration	7,900,000.00	
Earnest Money Deposit from CALOPTIMA CONCENTRATION ORANGE COUN 9-22-23		150,000.00
Closing funds from CALOPTIMA CONCENTRATION ORANGE COUN 9-22-23		7,882,802.37
ESCROW CHARGES:		
Escrow Fee Split	3,100.00	
Overnight Fee to Fidelity National Title Company	25.00	
Courier Fee to Fidelity National Title Company	75.00	
Recording Service Fee to Simplifile	22.50	
TITLE CHARGES:		
ALTA Extended Owners Policy for $7,900,000.00	1,699.00	
Endorsements to Fidelity National Title Company	7,995.00	
Survey Review to Fidelity National Title Company	75.00	
RECORDING FEES:		
County Transfer Tax- Split to Fidelity National Title Company	4,345.00	
PRORATIONS AND ADJUSTMENTS:		
Taxes from 7/1/2023 to 9/25/2023 based on the Annual amount of $29,791.62		7,034.13
Exclusive Negotiating Fee	120,000.00	
Sub Totals	8,037,336.50	8,039,836.50
Refund Due Buyer /Borrower	2,500.00	
Totals	8,039,836.50	8,039,836.50

It is agreed by the undersigned that the foregoing statement may change if a change in the escrow closing occurs or if other unforeseen contingencies arise. In the event changes in the statement become necessary, you are nevertheless authorized to close this escrow. It is understood that we will receive a final statement of account if the above totals are changed.

APPROVED AND ACCEPTED THIS 25th DAY OF September, 2023

Back to Agenda
Back to Item

FIDELITY NATIONAL TITLE COMPANY

3237 East Guasti Road, Suite 105, Ontario, CA 91761
Phone: (909) 569-0226 Fax: (800) 507-0841

Buyers/Borrowers Settlement Statement
Estimated

Escrow No: 30094459 - 012 JR **Close Date:** 09/25/2023 **Proration Date:** 09/25/2023 **Disbursement Date:**

Buyer(s)/Borrower(s):

Orange County Health Authority, a public agency

DocuSigned by:

By: Michael Hunn
CDDDBCC1968.94F8...

Name: Michael Hunn

Its: CEO

Continued to the November 2, 2023 Board of Directors Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
11. Approve Policy for Election of Officers

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Action
Approve policy for election of officers.

Background
At the September 7, 2023, Board of Directors (Board) meeting, Chair Clayton Corwin established the Governance Ad Hoc (Ad Hoc) Committee for the purposes of drafting the initial Board Rules of Procedures and a formal process for electing officers. Chair Corwin appointed Vice Chair Blair Contratto as the Ad Hoc Chair, along with Director Isabel Becerra and Supervisor Vicente Sarmiento to the Ad Hoc Committee.

Discussion
The Ad Hoc committee has met several times since the September Board meeting and reviewed current practices by surrounding health plans and other public agencies regarding the election of officers. CalOptima Health's bylaws require the Board to elect one Director to serve as the Board's Chair and another Director to serve as the Board's Vice Chair. This policy establishes the procedures by which the Board elects Directors to serve as Board Officers.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended action will formalize a process for electing officers of the Board.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Election of Officers Policy

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

Policy: GA.XXXX
Title: **Board of Directors' Officer Election Policy**
Department: Board of Directors
Section: Not Applicable

CEO Approval:

Effective Date: 10/XX/2023

Board-Proposed Draft Policy

I. BACKGROUND

CalOptima Health's bylaws require the Board to elect one Director to serve as the Board's Chair and elect another Director to serve as the Board's Vice Chair.[1] The Board Officers' terms commence on the first day of the month after the Organizational or Regular Meeting at which the Board Officer was elected and continue for a one (1)-year term, unless the Board Officer sooner resigns or is removed from office.[2] Board Officers may continue beyond the one (1)-year term if a successor has not yet been elected. In that instance, the Board Officer's term would end upon the election of a successor.[3] These elections must take place at an Organizational Meeting of the Board, unless the election is to replace a Board Officer who resigned or was removed prior to the completion of the term as a Board Officer.

II. PURPOSE

This policy establishes the procedures by which the Board elects Directors to serve as Board Officers.

III. POLICY

A. Definitions. The terms used below shall have the following definitions in this Policy GA.XXXX.

Term	Definition
Board	The Board of Directors for CalOptima Health.
Board Officer	A Director who holds the position of either Chair of the Board or Vice Chair of the Board.
Director	A voting member of the Board.
Organizational Meeting	The Board's annual organizational meeting, as designed by the Board under § 5.2(b) of CalOptima Health's bylaws.
Regular Meeting	The regular meetings scheduled by the Board under § 5.2 of CalOptima Health's bylaws.

B. Nominations. In the thirty (30) days prior to the Organizational Meeting or Regular Meeting at which an election for Board Officers will take place, CalOptima Health Legal Counsel will survey all Directors to determine which Directors have an interest in serving as a Board Officer. CalOptima Health Legal Counsel then will circulate that list of potential Board Officer nominees for each Officer position to all Directors. From that list of potential nominees, Directors may nominate other Directors or themselves for a Board Office position by submitting their nominations to CalOptima Health Legal Counsel. Directors must submit all nominations for a Board Officer to CalOptima

[1] CalOptima Health Bylaws §§ 8.1, 8.2.
[2] CalOptima Health Bylaws § 8.3.
[3] *Id.*

Health Legal Counsel at least ten (10) days prior to any Organizational Meeting or Regular Meeting at which the election will take place.

C. Elections.

1. *Requirements*. The election of Board Officers requires at least seven (7) Directors present at the Organizational or Regular Meeting at which the election takes place. The election of a Board Officer requires the vote of at least five (5) Directors for each Board Office.
2. *Procedure*. The Chair shall call the agenda item and turn the Board Officer election process over to CalOptima Health Legal Counsel. The Clerk of the Board (Clerk) will conduct the election for Board Officers with the assistance of CalOptima Health Legal Counsel. All Directors nominated under Section III.B shall appear on the initial ballot for the respective Board Officer position. The Clerk will distribute the ballots immediately prior to the vote, collect the ballots once completed by the Directors, count the ballots, and announce the results on the record. Voting shall be repeated as many times as necessary to obtain the required majority vote for any nominee for the Board Officer position. The Clerk will read the overall results of each vote into the record. If an election does not result in a nominee receiving the required five (5) votes after three (3) ballots, for each subsequent vote, the nominee with the fewest number of votes from the previous tally shall be removed from the ballot prior to the next vote at that same meeting. This procedure shall continue until there are only two (2) nominees remaining. In no event shall a name be struck from the ballot that leaves the ballot with only one (1) remaining nominee. If both the Board Chair and Vice Chair are elected at the same meeting, the Board Chair election shall take place first. If a nominee for Board Chair does not receive enough votes to become Chair, that Director shall automatically be placed on the ballot for the Vice Chair election.

D. Term Limits. The Chair and Vice Chair will each serve a limit of a one (1) full year term, respectively. If the Chair or Vice Chair is elected prior to the Organizational Meeting due to the early resignation or removal of the previous Chair or Vice Chair, the Chair or Vice Chair may serve the partial term until the Organizational Meeting and then serve the full one (1)-year term following the Organizational Meeting if re-elected. If the Chair is not re-elected the Vice Chair would ascend to the position of Chair. A Board Officer who reaches the term limit under this Section III.D may not hold the same Board Officer position again for a period of four (4) years. The Vice Chair shall automatically become Chair at the Chair's resignation or the end of the Chair's term under this section, unless (i) the Vice Chair notifies the Board prior to the end of the Chair's term that the Vice Chair does not wish to serve as the Chair, or (ii) the Vice Chair will not be a Director for the upcoming Board Officer term; in which case, the Board will elect a Chair and Vice Chair in accordance with the procedures in Sections III.B and III.C.

E. Interim Officers. If at least (7) Directors are not present for the Organizational or Regular Meeting, the current Board Officers will remain in place as interim Board Officers until the Board holds another election to select the Board Officers' replacements.

F. Records. After any election, the Clerk shall retain the election ballots for four (4) years. The Clerk will update and file with the California Secretary of State the "Statement of Facts: Roster of Public Agencies" form and any other filing required by government agencies each time there is a new Board Officer.

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

12. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ankura Consulting Group, LLC to Provide Professional Services to Review External Grants and Other Internal Initiatives

Contacts

John Tanner, Chief Compliance Officer, Office of Compliance, (657) 235-6997
Kevin Larson, Director Internal Audit, Internal Audit Department, (714) 246-8745

Recommended Actions

1. Authorize the Chief Executive Officer to execute a contract amendment with Ankura Consulting Group, LLC (Ankura) to consult and conduct grant funds review for compliance and audit readiness; and
2. Authorize allocation of budgeted but unused funds in the amount of $200,000 from Medi-Cal: Professional Fees in the Internal Audit Department to fund the contract amendment through June 30, 2024.

Background

As part of CalOptima Health's ongoing compliance and readiness for regulatory audits, staff selected and contracted with Ankura through a request for proposal process released on May 18, 2022. The Ankura contract is effective from October 18, 2022, through July 31, 2024.

During the compliance and audit readiness phase of the Ankura contract, staff realized the need for additional consulting services to review CalOptima Health's end-to-end grants and other Board-approved initiatives and programs. It is imperative that CalOptima Health ensure that adequate controls and oversight are in place to safeguard the grants, programs, and initiatives process from mismanagement, inefficiencies, and potential adverse audit findings.

Discussion

Ankura is currently under contract to provide consulting services to CalOptima Health to maintain preparedness for anticipated and ad-hoc regulatory audits by the Department of Health Care Services (DHCS) relative to its Medi-Cal program. Staff have identified the need for additional services relative to implementing sound business practices and maintaining audit readiness around CalOptima Health's grants and initiatives administration, which includes the administration of Board-approved programs that fund internal and external initiatives.

Staff recommends amending the Ankura contract to build upon the existing audit readiness services by adding a scope of work for consulting and review of CalOptima Health's grants administration process. The scope of work will direct Ankura to perform grant processing walk-throughs, application and approval assessments, and evaluate reporting, recordkeeping, accounting, and close-out effectiveness.

Back to Agenda

The overall grants and initiatives program requires CalOptima Health to manage approved funds in a fiscally responsible manner, according to DHCS requirements and industry best practices. Ankura is uniquely positioned to provide these additional consulting services to CalOptima Health given its familiarity with CalOptima Health's policies, procedures, and staffing model that Ankura is evaluating under its current audit readiness contract.

Expanding the services under Ankura's existing contract provides CalOptima Health with the best possible outcome for improving program compliance, strength, and readiness. Ankura has extensive experience investigating issues at the transactional level up to the board level. Ankura is well-positioned to research reporting and compliance issues that involve the designated use of funds and providing the appropriate level of documentation that ensures funds are being spent for the intended purposes.

Staff recommends allocating $200,000 in budgeted but unused funds for Medi-Cal: Professional Fees in the Internal Audit department under the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget. The expansion of the scope of work and resulting increase in total expenses allowed under CalOptima Health Policy GA.5002: Purchasing, requires Board action and approval.

Fiscal Impact
The recommended action is budget neutral. Unspent budgeted funds of $200,000 from Medi-Cal: Professional Fees in the Internal Audit Department approved in the FY 2023-24 Operating Budget will fund the total cost of the contract amendment through June 30, 2024. Management will include updated administrative expenses in future operating budgets.

Rationale for Recommendation
Ankura's expertise, in partnership with CalOptima Health, will ensure compliant and operationally efficient grants administration processes that are pre-tested and ready for future audit testing. Ankura has the requisite experience and subject matter expertise to evaluate the grants administration process. Furthermore, Ankura's present familiarity with CalOptima's business practices will produce efficiencies, resulting in less time and fewer costs to learn about the organization and develop solutions tailored to CalOptima Health's needs.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Additional Scope of Work – Grant Funds Review
3. Ankura Proposal for Grant Funds Review dated August 11, 2023

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

ATTACHMENT #1

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Ankura Consulting Group, LLC	485 Lexington Ave., 10th Floor	New York	NY	10017

Back to Item

Back to Agenda

August 11, 2023

CalOptima Health

Proposal for Grant Funds Review

Proposal Prepared For:

John Tanner
Chief Compliance Officer
505 City Parkway West
Orange, CA 92868

Nancy Huang
Chief Financial Officer
505 City Parkway West
Orange, CA 92868

James Novello
Kennaday, Leavitt, Owensby PC
601 Capital Mall, Suite 2500
Sacramento, CA 95814

8/11/2023

John Turner
Chief Compliance Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868

Re: Grant Funds Review Proposal

Dear John:

On behalf of Ankura Consulting Group, LLC ("Ankura," "the Firm," "us," "we"), we are pleased to submit the attached proposal (the "Proposal") in which Ankura would furnish professional advisory services associated the review of CalOptima's Grant Programs

This Proposal is provided by Ankura, a leading healthcare consulting firm whose members include some of the most seasoned, and well-known, compliance professionals in the United States. We have deep roots in the highly regulated healthcare and life sciences space, financial reporting, and financial internal controls, and specialize in assisting organizations of all sizes and strategic focus with their compliance and regulatory programs. Ankura has significant experience in reviewing grant funds that involve Federal and state funds.

We have specific experience in the services and specialties provided by CalOptima. We believe you will find that our Proposal offers a well-qualified team and a thoughtful, efficient, and cost-effective approach to assessing your overall grant program. We know that we can provide CalOptima with the necessary input and direction to ensure that its grant program has the appropriate internal controls to mitigate risk and achieve the desired outcomes. If you have any questions or concerns about the attached proposal, David Benkert can be reached at (213) 452-4513 or David.Benkert@ankura.com. Dorothy DeAngelis at (623) 208-3295 or Dorothy.Deangelis@ankura.com.

Sincerely,

Ankura Consulting Group, LLC

David Benkert
Senior Managing Director

Dorothy DeAngelis
Senior Managing Director
Healthcare and Life Science Practice Leader

Back to Item

Back to Agenda

Contents

Background – About Ankura

Ankura is a business advisory and expert services firm defined by HOW we solve challenges.

Whether a client is facing an immediate business challenge, trying to increase the value of their company, or protecting against future risks, **Ankura designs, develops, and executes tailored solutions** by assembling the right combination of expertise.

We build on this experience with every case, client, and situation, collaborating to create innovative, customized solutions, and strategies designed for today's ever-changing business environment. This **gives our clients unparalleled insight and experience across** a wide range of economic, governance, and regulatory challenges.

Solutions that deliver holistic, meaningful, and sustainable results.

- Analytics & Digital Transformation
- Cybersecurity
- Economics & Statistics
- Investigations & Accounting Advisory
- Litigation, Arbitration, & Disputes
- Risk Management & Compliance Advisory
- Strategy & Operations
- Transaction Advisory Services
- Turnaround & Restructuring

Our unique blend of subject-matter expertise, wealth of cross-disciplinary and cross-industry experience, and proven track record enable us to deliver tailored, effective solutions and unparalleled service in a broad range of matters.

- Construction
- Energy
- Financial Services
- Global Infrastructure & Real Estate
- Healthcare
- Insurance
- Public Sector

Collaboration allows us to achieve a level of success we never thought possible. When talented individuals from different backgrounds are brought together and encouraged to work as a team, the result is innovation and success. Our unique blend of subject-matter expertise, a wealth of cross-disciplinary and cross-industry experience, and a proven track record enable us to deliver tailored, effective solutions and unparalleled service in a broad range of matters.

Location of Headquarters

Ankura Consulting Group, LLC has offices and resides in various locations throughout the United States. This proposal was prepared by the Disputes and Economics Health Care and Life Sciences Group, which has a base of operations at 515 South Flower St. | Suite 3650 |Los Angeles, CA, 90071.

Qualifications

Ankura's Healthcare Practice has extensive experience assisting health plans and other healthcare entities complying with the complex regulatory and policy requirements associated with government and commercial programs. Our experts' partner with clients to design, implement, and enhance their compliance programs to adhere to prevailing requirements and industry best practices, including those from the Office of the Inspector General ("OIG"), the Department of Justice ("DOJ"), and the Health Care Compliance Association ("HCCA"). We help our clients build robust and sustainable programs that fit the unique needs of their organization and establish the foundation to identify and mitigate current and future compliance risks.

Our professionals also have deep expertise within the California healthcare regulatory environment and our work involves detailed compliance, audit, and operational reviews against Department of Managed Care ("DMHC") and Department of Health Care Services ("DHCS") requirements. We are familiar with the unique challenges facing organizations with Medi-Cal contracts and the importance of evolving their compliance programs to keep up with the dynamic California regulatory environment and its risks.

Ankura has worked with many of the United States' leading managed care organizations, professional medical providers, hospitals, health systems, pharmaceuticals, biotech, and other provider, payor, and manufacturing organizations. In developing the staffing model for the work covered by this Proposal, we carefully selected a group of dedicated financial and consulting professionals with financial reporting, grant reporting, California-managed care, and compliance expertise, who will bring to the table a deep understanding of the unique needs and concerns of CalOptima and will provide you with excellent - and pragmatic - counsel and guidance to address those needs and concerns.

Preparedness to Deliver Results

We concentrate on healthcare organizations and are routinely engaged to perform the following services:

- Serving Compliance Experts, Monitors, and Board Experts for organizations navigating CIAs (e.g., focus arrangements, financial reporting, and disclosure Issues, compliance program enhancement, claims/coding reviews, training and education, and risk evaluation and mitigation program reviews)
- Financial and regulatory reporting
- Compliance program effectiveness assessments
- Compliance program development

- Coverage analysis and other research participant billing consulting support
- Privacy / HIPAA / HITECH advisory services
- Compliance and Regulatory Risk Assessments
- Assistance with preparing annual compliance work plans
- Advice and perspectives associated with interpreting compliance trends and aiding clients that seek to prepare for regulatory changes
- Interim management support (Compliance Officer, Privacy, HRPP, Research)
- Creation of policies which is often accompanied by the delivery of associated training and education
- Investigations support and expert testimony

Experience with Financial Reporting and Compliance

In developing the staffing model for the work covered by this Proposal, we carefully selected a group of dedicated consulting professionals with financial reporting, accounting, internal controls, compliance, California-managed care, and operational expertise who bring to the table a deep understanding of the unique needs and concerns of CalOptima and will provide you with excellent counsel and guidance to address those needs and concerns.

Relevant Engagement Descriptions

- Retained by the Board of Directors of a health plan to investigate allegations that Federal Grants funds provided to a health plan were not fully utilized and unused grant funds were not refunded. Our engagement involved the review of how funds were spent and evaluating the appropriateness and sufficiency of the support. We also reviewed the metrics that identified how the funds were to be disbursed.

- Ankura provided a review of Federal Grant Funds for an FQHC to determine if the grant practices complied with Federal Grant guidelines. Our services included the review of practices and procedures, review of supporting documentation and reporting requirements to ensure that the Organization complies with Federal Requirements

- Retained by the Board of Directors of an international not-for-profit organization to conduct a forensic accounting analysis to investigate allegations by the United States DOJ and a local state attorney general that donations were improperly used to the benefit of its founder and the founder's related entities and that expenditures were not used to benefit the organization's mission. The engagement involved a review of donations received, a review of expenditures, and supporting documentation to identify the purpose of the expenditure and who received the paid funds for four years. The results of our findings to the United States DOJ, Federal Bureau of Investigation, and state investigators.

- Ankura has provided ongoing support to a Southern California-based Management Services Organization ("MSO") to evaluate and update its policies and procedures to comply with applicable requirements, including all Medi-Cal program standards. We have developed and assisted in the implementation of an internal oversight program to better monitor, identify, and remediate compliance risks. We have also assisted the client before, during, and after regulatory, accreditation, and health plan audits to address compliance gaps.

- Ankura professionals served as the financial monitor for a California-based Medicare/Medi-Cal Managed Care Health plan. The roles and responsibilities focused on working with management to develop and implement successful corrective action. As a monitor appointed by the California Department of Managed Healthcare, the monitor had a dual reporting role

with the board of the health plan and the Department of Managed Healthcare. Our responsibilities included:

  - Oversight of daily financial activities of the corporation, financial reporting, budgeting, Medicare cost reimbursements, financial forecasting, hospital, and physician contracting, development of corporate policies and procedures, establishment of corporate overhead departmental reporting, and development of audit programs and internal control procedures.
  - Development of oversight and dashboard monitoring reports that the board used to monitor the progress of financial corrective action plans, financial forecasting, and operational and compliance programs.

- Ankura provided investigative assistance for a managed care plan related to a program compliance matter involving patient billing and cost report issues. Our assistance included performing a compliance review of the organization's billing practices and an analysis of the revenue flow to the various supporting entities.

Grant Funds Review

Our Understanding of Your Needs

Our team has extensive California health plan experience that includes operational and compliance issues with Medi-Cal, Medicare Advantage plans, and commercial payors. Our experience includes investigating issues at the transactional level up to the board level. Our team has extensive experience with reporting and compliance issues that involve the designated use of funds and providing the appropriate level of documentation that ensures that funds are being spent for the intended purposes.

Our team also has extensive experience in evaluating the effectiveness of internal controls and providing solutions when internal controls fail.

Grant Funds Review Services

Our overall approach to these types of projects is to collaborate with our clients. Before launching off into an in-depth analysis, we meet with the key client representatives to discuss the scope of our work and develop a better understanding of the issues and the organizational and financial operations of the organization.

Once we have developed that understanding, we employ a focused approach to request the relevant documents, speak to the appropriate company personnel, perform the appropriate analyses that respond to the issues, and allow us to develop our findings and recommendations. Often during the investigation, we will identify additional issues, but before we expand our

procedures to investigate the new issues further, we will discuss with counsel and the client to determine how we should proceed.

Ankura's approach for this engagement will be designed to understand, assess, and review CalOptima's grant programs from pre-award to close-out. This approach will allow us to assess the grant program holistically. We will consider the existing internal controls as well as existing auditing and monitoring processes in place to ensure grants are administered in accordance with the approved application, budget, and the terms and conditions of each award. Our review will also provide insight into the program design to ensure policies and procedures are appropriate to document metrics and demonstrate the success of each initiative.

Our procedures will be designed to provide CalOptima with a better understanding of the grant funds process and potential program design and administration weaknesses, exposures, and compliance oversight deficiencies. The development of our scope of work and work plan will include procedures for the grant program as well as the inter-governmental transfer program. When we discuss grant program procedures it will include the inter-governmental transfer activity.

I. Scope of Work and Planning

We approach this engagement, like all engagements, collaboratively. While we are providing our independent review and conducting procedures that we feel are appropriate under the circumstances, we recognize that our client partners play a key role in achieving a thorough and complete review.

We begin our work with a kickoff call with key stakeholders involved with the grant process with our Ankura team. We would expect that the kickoff meeting typically includes:

- Compliance Officer
- Chief Financial Officer
- Chief Operating Officer
- Chief Strategy Officer
- Other key stakeholders involved with the grant award, management, and funding process

At the onset of the engagement, Ankura will work with CalOptima's team to discuss the scope of work that identify the areas of the grant program that you would want Ankura to address. Based on the defined scope of work we will develop a comprehensive work plan outlining the key steps, milestones, and timeline for the review. This work plan will be used to guide the duration of the engagement. A key part of the work plan will be to build periodic check-ins with leadership to stay apprised of project progress, potential issues, and identified risks.

Initially, we will develop an understanding of CalOptima's grant process through a review of the policies and procedures and meetings with the individuals responsible for implementing those practices. Once we complete our initial document review and interview process, we will request additional specific program documents.

II. Document Review

After agreement on the project work plan, Ankura will develop and issue a document request list outlining the information needed to evaluate CalOptima's existing grant administration program. Materials anticipated to be requested from CalOptima for this evaluation include but are not limited to the following:

- An organizational chart of the individuals involved with the grant process including reporting structure;
- Job descriptions for team members involved in the grant process;
- Grant program and intergovernmental transfer policies and procedures inclusive of those relevant to the development, execution, and review of grant programs;
- Listing of grant programs that have been closed, in process, and those grants that are in the approval process to include
    - Contract amounts, recipients, and terms
    - Funding sources, applicable guidance, and requirements;
- Listing of Intergovernmental transfers that are in process, closed, or in the approval process;
- Program development procedures;
- The grant application, approval, and denial policies and procedures;
- Auditing and monitoring policies and procedures;
- Notices of grant awards, memorandums of understanding, grant agreements, and any other award notification, allowable cost and activities, and reporting documentation requirements;
- Success metrics, performance progress reports, and tracking procedures for measuring program success.

III. Interviews

Following our review of CalOptima's documentation, Ankura will conduct interviews with select CalOptima staff to gather further insight into established processes. Interviewees may include but are not limited to the following:

- Chief Compliance Officer;
- Chief Financial Officer;
- Chief Strategy Office;

- Grant Subject Matter experts, and
- Board representative(s).

The interviews will be used to probe the processes described within submitted documentation and assess the effectiveness of processes, internal controls, and compliance. Our analysis will be to evaluate CalOptima's best practices for grant funding compliance.

IV. Review of Grant Activity

Once we have a full understanding of the grant policies and procedures, program documents, and transaction activity we will work with the leadership team to select specific grants and inter-governmental transfers to review. The criteria for the selected grants will be based on an evaluation by Ankura in consultation with the Leadership team input. We will request all the relevant transaction documents related to the selected grants and conduct a walk-through of the grant from its approval process through funding, reporting, and close out. Based on the results of our review of the selected grants and discussion with the leadership team we may suggest that we expand our review to additional grants.

V. Reporting

After our review, we will prepare a report that outlines the following:

- Scope of Work;
- Procedures performed;
- Documents reviewed;
- Analyses performed;
- Findings, and
- Recommendations

Our findings will identify specific issues, weaknesses, and reoccurring issues that we identified during our document review, interviews, and transaction walk-throughs.

In response to each finding, we will provide recommendations that may improve the overall program design, internal controls, program compliance, and oversight functions. These recommendations will include suggestions that will increase the effectiveness of accounting and reporting, risk assessments, and internal controls as they relate to the grant process as well as ensure programs are designed and operated effectively to demonstrate the success of each initiative.

Our Team

We have included biographies for the Ankura members that we propose to use on this project. Our professionals have worked with many of the United States' leading managed care companies, post-acute care providers, hospitals, health systems, pharmaceutical, biotech and other provider, payor, and manufacturing organizations. In developing the proposed staffing for the work covered by this proposal, we carefully selected a group of dedicated consulting

professionals who will bring to the table a deep understanding of the unique needs and concerns of CalOptima.

The scope of work described above suggests that several important skill sets and expertise may be requited and we are combining professionals with extensive healthcare financial reporting experience, grant review and oversite experience, and internal controls experience. Our team experience extends to the board level, we provide guidance and education regarding what boards need to know and how to fulfill their oversite responsibilities. We may deploy additional staff that bring specialized consulting/advisory skills to our project team as needed to ensure you obtain the best service most efficiently.

	**David E. Benkert** is a Senior Managing Director at Ankura, based in Los Angeles. For over three decades he has been providing clients with solutions to their financial, regulatory, and compliance oversight issues. These activities have included health plan monitor, health plan financial and operational consulting, financial reporting, compliance reviews, forensic investigations, insolvency issues, board education, financial performance reviews, and forecasting & planning. David provides these services for organization management, boards of directors for public and non-public organizations, and not-for-profit organizations. Additionally, he has provided services for federal and state regulators. David is a Certified Public Accountant and certified in Financial Forensics.
	**Kasie Ray** is a Director at Ankura based in Nashville. She is an experienced compliance professional with expertise in multiple areas including Healthcare compliance, state and federal grant administration and compliance, and Human Resources. Kasie served as a state-wide program administrator and compliance specialist for federal grant programs, responsible for the compliance oversight of over 3 million dollars in funding. Kasie developed and conducted compliance audits for various grant awards from federal agencies such as the Office of Community Services (OCS), Department of Veterans Affairs (VA), Health and Human Services (HHS), and the Department of Housing and Urban Development (HUD). Additionally, Kasie is experienced in assessing the implementation and effectiveness of healthcare and HR compliance programs as well as the development and monitoring of corrective action plans.

	**Katy Dettman** is a Managing Director in the Ankura Office of the CFO™ practice, where she specializes in healthcare accounting/ finance, internal audit, and management consulting. Katy led an internal audit team that included risk assessments, internal audits, and special projects. She also led continuous improvement initiatives that focused on increased effectiveness of accounting and reporting, assessing risks and internal controls across a variety of healthcare organizations, including not-for-profit organizations.
	**Dorothy DeAngelis** is a Senior Managing Director at Ankura, based in Phoenix. Her expertise is in healthcare compliance, investigations, and disputes. Dorothy provides consulting services relating to regulatory compliance and operations in the commercial and government-sponsored programs space. Her experience includes working with payers with government contracts (Knox-Keene Act, Medicare Advantage, and Part D, Medicaid and Medi-Cal, Medicare/Medicaid Duals programs, Tricare, and the Affordable Care Act), providers (Medical Service Organizations and IPAs), pharmacies, and pharmaceutical manufacturers. Dorothy has performed numerous risk assessments, compliance, and delegation oversight program implementations, and compliance program effectiveness measurement assessments.
	Kelli Howe is a Managing Director at Ankura, with over ten years of healthcare experience working with a diverse range of clients including the Centers for Medicare & Medicaid Services (CMS), health plans, pharmacy benefit managers (PBMs), third-party administrators (TPAs), and health systems. Her expertise is in government programs compliance and operations. Kelli has engaged with numerous clients throughout all stages of the CMS program audit lifecycle and has extensive experience with the regulatory and sub-regulatory guidance governing these audits. She specializes in leveraging health plan data, including CMS program audit data universes, to diagnose compliance risks and identify opportunities to improve operational efficiency.

Fees and Expenses

Fees

Based on the preliminary information obtained from the Website and information and our discussions we have prepared a budget that anticipates that we will conduct interviews with key stakeholders and the grant management staff, review about 50 percent of the grants that

CalOptima has approved, prepare a report that identifies our findings and recommendations, and present our report to the Board of Directors. We have estimated that our professional fees for this engagement will range between $150,000 to $200,000. Once we have finalized our Scope of Work and complete a preliminary review of documents, we will provide an updated budget.

Our engagement fee estimate was developed using the following billing rates.

Ankura Title	CalOptima Health Hourly Billing Rate
Senior Managing Director	$500
Managing Director	$425
Senior Director	$375
Director	$325
Senior Associate	$275
Associate	$225

Expenses Reimbursement

If selected for this work and to the extent that Ankura incurs travel or other expenses, Ankura shall be entitled to reimbursement of its actual, reasonable out-of-pocket and direct expenses incurred regarding the services to be provided under this engagement, including travel and lodging (without markup).

Compliance and Quality Control

Ankura brings a dedicated and highly effective team structure to our engagements. Ankura leverages a team structure designed to maximize partnership and collaboration throughout the engagement. Our team will communicate with CalOptima's senior leadership throughout the review process regarding our findings and recommendations.

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Approve Actions Related to the CalOptima Health Community Reinvestment Program for Medi-Cal Members for Calendar Year 2024

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Peter Bastone, Chief Strategy Officer, (714) 246-8549

Recommended Actions

1. Direct the Chief Executive Officer, or designees, to make an initial commitment of up to $38 million from undesignated reserves for the purpose of community reinvestment activities to be implemented in Calendar Year (CY) 2024 for Medi-Cal members.
2. Direct the Chief Executive Officer, or designees, to make subsequent funding allocations to ensure that CalOptima Health complies with the California Department of Health Care Services (DHCS) minimum contract requirements and CalOptima Health's commitment of up to 20% of annual Medi-Cal net operating income for future years.

Background

Starting January 1, 2024, as part of the revised Medi-Cal Managed Care Plan (MCP) contract, DHCS is requiring all MCPs to reinvest a portion of their net income in their local communities through community reinvestment activities, as follows:

- 5% of the portion of annual net income that is less than or equal to 7.5% of revenue for the year; and
- 7.5% of the portion of annual net income that is greater than 7.5% of revenue for the year.

Beginning January 1, 2024, CalOptima Health will need to meet these required levels of community reinvestment.

In addition, DHCS has also instituted a related 2024 contract requirement for meeting quality metrics. If the plan does not meet required quality outcome metrics, an additional 7.5% of annual net income must be reinvested in the community.

DHCS will release more detailed guidance on these requirements, including requirements for developing the required Community Reinvestment Plan.

Discussion

Based on CalOptima Health's most recent financial performance and the new DHCS contract provisions, staff estimates that the annual fiscal impact, in aggregate, will be approximately 12% to 13% of annual Medi-Cal net operating income. To demonstrate CalOptima Health's commitment to the

Back to Agenda

Orange County safety net, beginning with CY 2024, CalOptima Health recommends a community reinvestment level of up to 20% of annual Medi-Cal net operating income.

As an initial deposit to establish a fund for the Community Reinvestment Program, staff recommends a commitment of up to $38 million, calculated from 20% of FY 2022-23 Medi-Cal net operating income of $188.3 million as reported in CalOptima Health's audited financials. This will allow staff to better prepare and plan for community reinvestment activities prior to the DHCS contract provisions taking effect on January 1, 2024.

Staff will return to the Board at a future meeting to provide information on the Community Reinvestment Plan and to request authorization and allocation of funds for recommended community reinvestment activities under the plan. Addressing equity gaps in quality and access to care will be a key focus of investment.

Fiscal Impact
The recommended action to commit up to $38 million to community reinvestment activities for Medi-Cal members will be funded from undesignated reserves.

Rationale for Recommendation
The 20% of annual Medi-Cal net operating income investment threshold is recommended to demonstrate CalOptima Health's strong commitment to reinvestment in Orange County, over and above the contractually required thresholds. As demonstrated by recent community reinvestment efforts, CalOptima Health is committed to making significant investments in community organizations to increase quality of care and health equity.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None.

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
14. Approve Actions Related to the Housing and Homelessness Incentive Program

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions
1. Approve CalOptima Health staff recommendations to administer grant agreements and total award payments up to $52.3 million to selected grant recipients (listed in Attachment 2) for Capital Projects to increase the current affordable and permanent housing pool.

Background
In March 2023, the Board of Directors (Board) approved actions related to the Housing and Homeless Incentive Program (HHIP) Priority 3: Capital Projects, including committing unused funds totaling $6.65 million from the first HHIP notice of funding opportunity (NOFO), along with $12.6 million in earned incentive dollars from the California Department of Health Care Services (DHCS) obtained for completion of the Local Homelessness Plan and the Investment Plan. The actions committed a total of $19.25 million to capital projects.

Then, in June 2023, the Board approved actions related to the HHIP Priority 3: Capital Projects, including total funding available for the next notice of funding opportunity of $52.3 million. This total included $19.25 million from the March action, $10.75 million from new HHIP incentive funding from the DHCS for HHIP Submission 1, and a new $22.3 million allocation from existing reserves. It was anticipated that this community investment would positively impact and facilitate the development of housing options for people experiencing homelessness throughout the county, one of the greatest identified barriers to addressing the homelessness crisis. The Board also authorized CalOptima Health staff to develop scopes of work to be used in notices of funding opportunities to grant out the $52.3 million in capital project awards.

Discussion
The NOFO was released to the public on June 22, 2023, via distribution lists and on the CalOptima Health website. CalOptima Health staff conducted a community forum for all interested community organizations describing the grant application process, funding priority areas, applicant eligibility criteria, and responded to questions ahead of the open-portal application period, which ran from June 22, 2023 to August 15, 2023. In total, CalOptima Health received and reviewed 27 completed proposals from 27 unique organizations. An internal committee of evaluators from CalOptima Health reviewed and scored the submitted proposals; 15 of the proposals received recommendations for full or partial funding totaling the full $52.3 million allocated to the priority area. With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 2.

Back to Agenda

Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact
The recommended action has no additional fiscal impact. Previous Board actions on March 2, 2023, and June 1, 2023, allocated $52.3 million, in aggregate, to HHIP Priority 3, Capital Projects.

Rationale for Recommendation
Funding these programs and projects will aid CalOptima Health in meeting HHIP measures, through which CalOptima Health can receive additional funding that will enable even more investments in the community to address homelessness.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Organizations Selected for Award and Recommended Amounts
3. Presentation of NOFO Process and Funding Recommendations

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
March 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$19,250,000
June 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$52,300,000

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

Attachment to the October 5, 2023 Board of Directors Meeting – Agenda 14

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Housing Authority	201 S. Anaheim Blvd, Ste 1003	Anaheim	CA	92805
C&C Development	14211 Yorba Linda St. #200	Tustin	CA	92868
City of Anaheim - Housing and Community Development Department	201 S Anaheim Blvd., Suite 1001	Anaheim	CA	92805
City of Brea	1 Civic Center Cirlce	Brea	CA	92821
City of Yorba Linda	4845 Casa Loma Avenue	Yorba Linda	CA	92886
Community Development Partners	3416 Via Oporto, Suite 301	Newport Beach	CA	92663
Families Forward	8 Thomas	Irvine	CA	92618
Illumination Foundation	2871 Pullman St	Santa Ana	CA	92705
Jamboree Housing Corporation	17701 Cowan Avenue	Suite 200	CA	92614
Kingdom Causes dba City Net	4508 Atlantic Avenue, Suite 292	Long Beach	CA	90807
Mercy Housing California	1500 South Grand Ave Suite 100	Los Angeles	CA	90015
National Community Renaissance of California	9692 Haven Avenue	Rancho Cucamonga	CA	91730
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	17821 17th Street, Suite 120	Tustin	CA	92780
The Eli Home	1175 N. East Street	Anaheim	CA	92805
WISEplace	1411 N Broadway	Santa Ana	US-CA	92706

Back to Item

Back to Agenda

Attachment to the October 5, 2023 Board of Directors Meeting – Agenda 14

ORGANIZATIONS SELECTED FOR AWARD AND RECOMMENDED AMOUNTS

Name	Grant Amount
Anaheim Housing Authority	$3,878,420
C&C Development	$8,000,000
City of Anaheim - Housing and Community Development Department	$1,500,000
City of Brea	$6,028,492
City of Yorba Linda	$3,100,000
Community Development Partners	$8,000,000
Families Forward	$2,500,000
Illumination Foundation	$3,000,000
Jamboree Housing Corporation	$4,721,241
Kingdom Causes dba City Net	$1,337,170
Mercy Housing California	$1,500,000
National Community Renaissance of California	$1,334,677
Shelter Providers of Orange County, Inc., dba HomeAid Orange County	$1,400,000
The Eli Home	$5,000,000
WISEplace	$1,000,000

Back to Item

Back to Agenda

Housing and Homeless Incentive Program (HHIP): NOFO Round 2 Recommended Funding Decisions

Board of Directors Meeting

October 5, 2023

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Back to Item

Back to Agenda

What Funding Makes up the $52.3M ?

- March 2023 Board Action committed $19.25M to Capital Priority:
  - $6.65M leftover from NOFO Round 1 (board-allocated reserves)
  - $4.2M for the Local Homelessness Plan (DHCS HHIP incentives)
  - $8.4M for the Investment Plan (DHCS HHIP incentives)

- June 2023 Board Action added the following to Capital Priority:
  - $10.75M for Submission 1 (DHCS HHIP incentives)
  - $22.3M new board-designated match

- Total Capital Priority funding opportunity of $52.3M

Back to Item

Back to Agenda

Within the Context of CalAIM

- Central Goal:
  - Identify and manage comprehensive needs through whole person care approaches and social drivers of health.
- Challenges:
  - Dearth of affordable and permanent supportive housing in Orange County.
  - High expectations from DHCS for our HHIP metrics: to house 20% more members over last year's effort and keep 85% housed over the course of a year.
- Resulting Approach:
  - Fund capital projects to accelerate bringing affordable and permanent supportive housing units online.

Back to Item

Back to Agenda

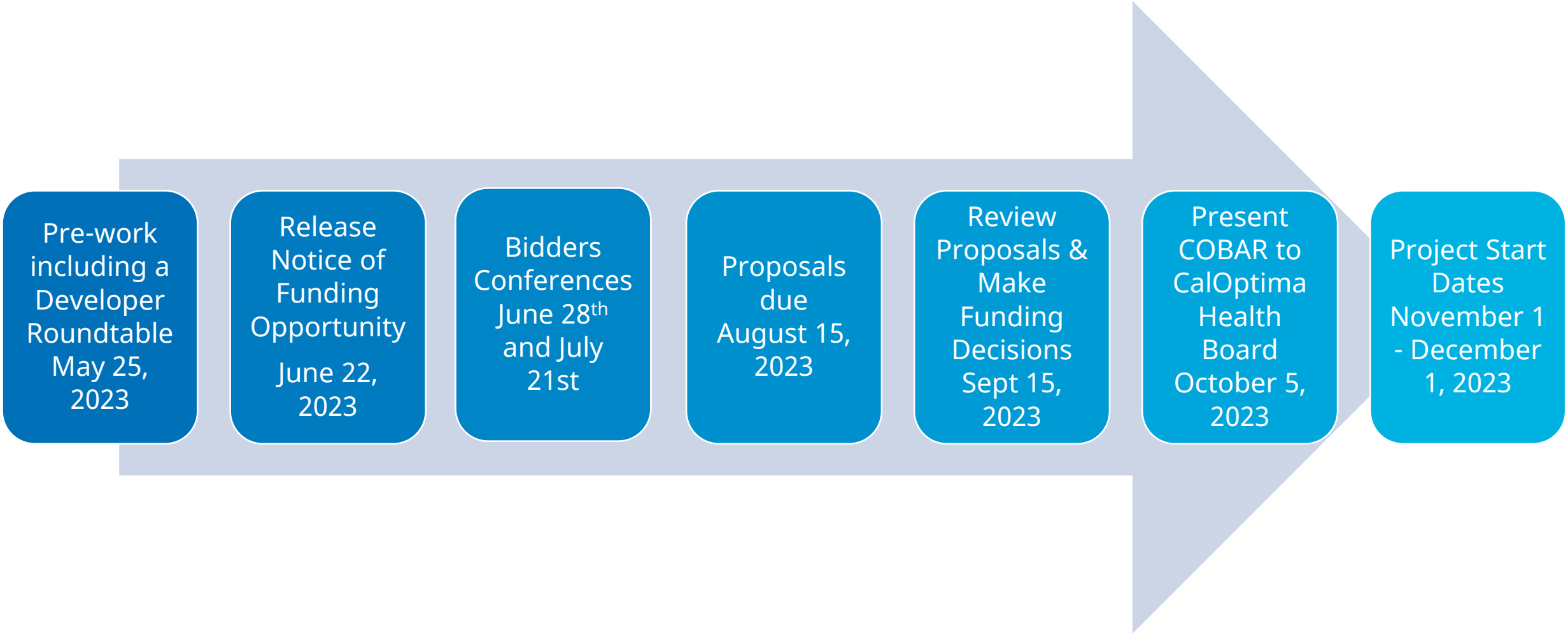
Purpose of Investments

- Continue to execute our HHIP Investment Strategy.
- Progress on DHCS metrics that will help CalOptima Health and Orange County access additional incentive dollars.

- Better serve ALL CalOptima Health members through investment in capital projects that bring online more affordable and permanent supportive housing units.

Back to Item
Back to Agenda

Solicitation and Review Process



Back to Item
Back to Agenda

Scoring Criteria

	Criterion	Maximum Points	Description of basis for assigning points
1	CalOptima Health core value alignment	15	– Project is trauma-informed, inclusive, non-residency restricted, low barrier, person-centered, and aligned with housing-first and harm-reduction principles.
2	Project Implementation	10	– Plan is complete and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success.

3	Budget and Financial Management	15	– Projects is sustainable beyond this funding opportunity if awarded and does not require continuous funding.
			– Additional funding sources are secured and meet the minimum threshold of secured funding.
			  – 5 points = 50%–75% of funding secured
			  – 15 points = 75% or more of funding secured

4	Affordability	5	– Reasonable ratio of units added vs. total project cost
5	Housing Experience	20	– Demonstrable experience in developing housing options for people experiencing homelessness in Orange County. – Applicants who have experience with similar projects in the past may receive more points.
6	Capacity of Applicant	5	– Able to demonstrate financial and management capacity to carry out the project, as evidenced in the submission of required materials in application portal.
7	Support Service Planning	10	– Applicant demonstrates how people served at this project will have access or referral to supportive services. – Application packet includes a letter of commitment or attestation regarding the plan for support services.
8	Project Readiness	15	– Projects that can launch soon after the grant award will receive more points. – If the applicant has site control and/or a location has been determined, more points will be awarded.
9	Housing type	15	– Permanent and affordable housing projects will receive more points based on those housing types being prioritized through this funding opportunity. – Projects that include units designated for “extremely low income” (rent at 30% AMI or less) will receive more points. – Provision of a housing service or type of housing that meets a need/fills a service deficit in Orange County.
	Total Earnable Points	**110**	

Back to Item

Back to Agenda

NOFO Round 2 Outreach

Meetings Hosted: Attendance	E-Blasts
Developer Roundtable: 35 In-Person Attendees	CalOptima Community Engagement E-News
June Bidders Conference: 107 Registrants	CalOptima Government Affairs E-Lists
July Bidders Conference: 94 Registrants	County of Orange Continuum of Care E-List
	Local Housing Authorities

- All documents shared and still available on our website: https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/FundingOpportunities

Proposals Received

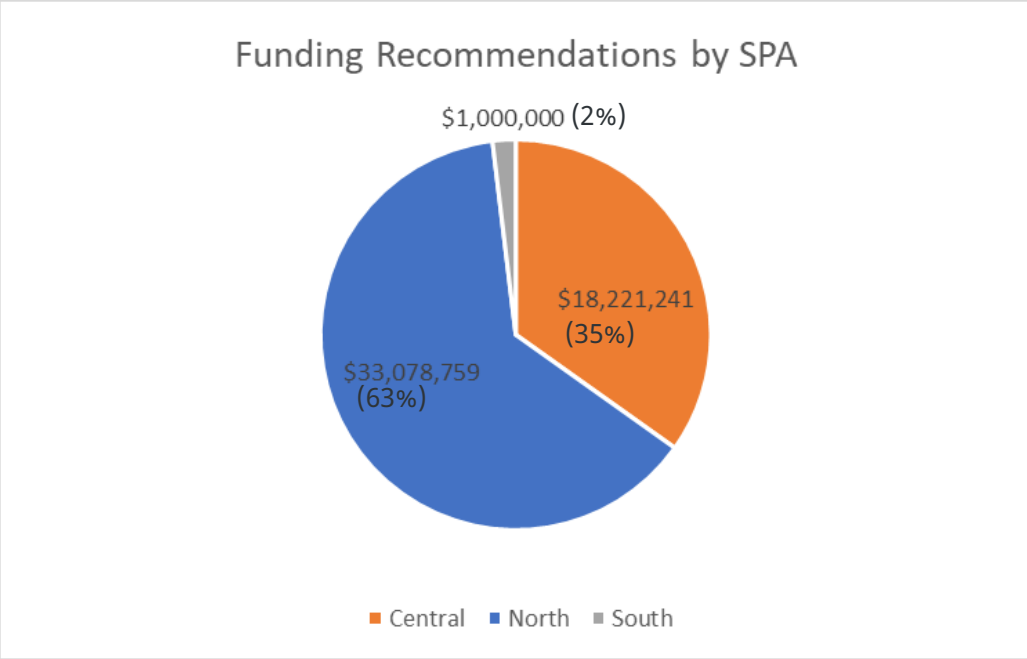
Grant Type	Maximum Allocation	Total Funding Requested	Proposals Received
Capital Grants	$52,300,000.00	$103,772,552.49	27

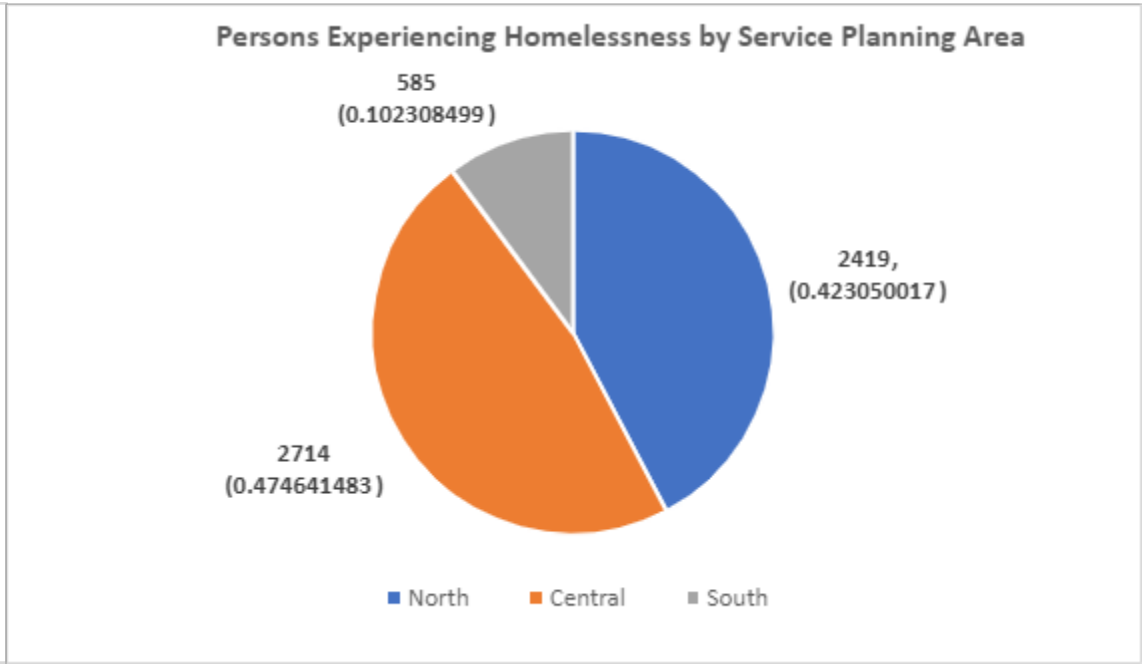
- Recommending full spend out of $52.3M allocation to fund 15 proposals.

Back to Item

Back to Agenda

Spread of Capital Investments





Recommendation*	Central	North	South	Countywide
Fund	4 (44%)	9 (60%)	1 (50%)	
Partial Fund		1 (7%)		
Do Not Fund	5 (56%)	5 (33%)	1 (50%)	1 (100%)
Total Applications	**9**	**15**	**2**	**1**

Back to Item

Back to Agenda

Capacity Grants

Organization Name	Total Funding Request	Funding Award	Number of Units	Brief Description
Anaheim Housing Authority	$3,878,420	$3,878,420	89	AHA was awarded a State Homekey grant enabling acquisition of North Harbor Apartments site. The property, a former Studio 6 Extended Stay motel, was lightly rehabilitated and currently serving as interim non-congregate shelter. The Project is now transitioning to PSH. Unit count includes 2 manager units.
C&C Development	$8,000,000	$8,000,000	55	Lincoln Avenue Apartments in Buena Park, is the proposed new construction of a 55-unit affordable family affordable community with 13 PSH units for individuals experiencing homelessness sourced through the CES. Eleven (11) units will be restricted by the County and two (2) remaining units will be restricted by the OCHFT.
City of Anaheim - Housing and Community Development Department	$1,500,000	$1,500,000	102	Finamore Place is a new construction housing development for large families and formerly homeless families. The project is 100% affordable, with 20 supportive housing apartments reserved for people coming from homelessness. The City of Anaheim selected Jamboree to develop Finamore Place.
City of Yorba Linda	$3,100,000	$3,100,000	66	The City of Yorba Linda is looking to acquire seven additional condominium units that will become affordable housing for low-income seniors. The property will also house an on-site manager.
Community Development Partners	$8,000,000	$8,000,000	87	The project will offer affordable housing with on-site supportive services tailored to extremely low-income veterans (VALBHS) , individuals with a serious mental illness (OCHCA), and senior affordable units (Mercy House). The planned renovation in Costa Mesa will remodel the current motel rooms into 87 units, including manager units.

Back to Item

Back to Agenda

Capacity Grants

Organization Name	Total Funding Request	Funding Award	Number of Units	Brief Description
Families Forward	$2,500,000	$2,500,000	8	Families Forward will acquire a parcel of land and build up to 8 units at 1852 San Juan in Tustin. These units will be affordable housing for families with minor-age children who are literally or at-risk of becoming homeless and extremely-low (30% AMI) to low income (80% AMI). A site plan has already been drafted by the architects.
Illumination Foundation	$3,000,000	$3,000,000	11	IF will acquire, develop, and rehabilitate the Santa Ana property - yielding 11 units at this property to create the Richard Lehn Intergenerational Campus. The project will serve homeless seniors and Transition Age Youth (TAY) single parent families with children. A shared housing model will be used for some, but not all, of the units.
Jamboree Housing Corporation	$4,721,241	$4,721,241	89	Estrella Springs in Santa Ana is a reuse project that will convert an existing motel into 89 units of PSH for veterans and people experiencing homelessness. Funding will be used to pay for cost overruns related to unforeseen conditions discovered during renovations and related COVID-19 impacts and delays for 55 non-VASH units. CES will also be utilized to place individuals into the units.
Kingdom Causes dba City Net	$1,337,170	$1,337,170	20	Project is comprised of 20-unit multifamily housing development project on a site located in Buena Park. The project will include ADA accommodations and individual self-contained living suites with dedicated bathrooms and kitchenettes. This projects leverages pre-fab modules which is expected to cut down on time to project completion.
Mercy Housing California	$1,500,000	$1,500,000	50	Villa St. Joseph is an adaptive reuse rehabilitation project located in the city of Orange. The project converts the former convent of the Sisters of St. Joseph of Orange into 50 units of affordable senior housing apartments with 18 units reserved for formerly homeless seniors. One unit will be reserved for an on-site manager. CES will also be utilized to place individuals into the units.

Back to Item

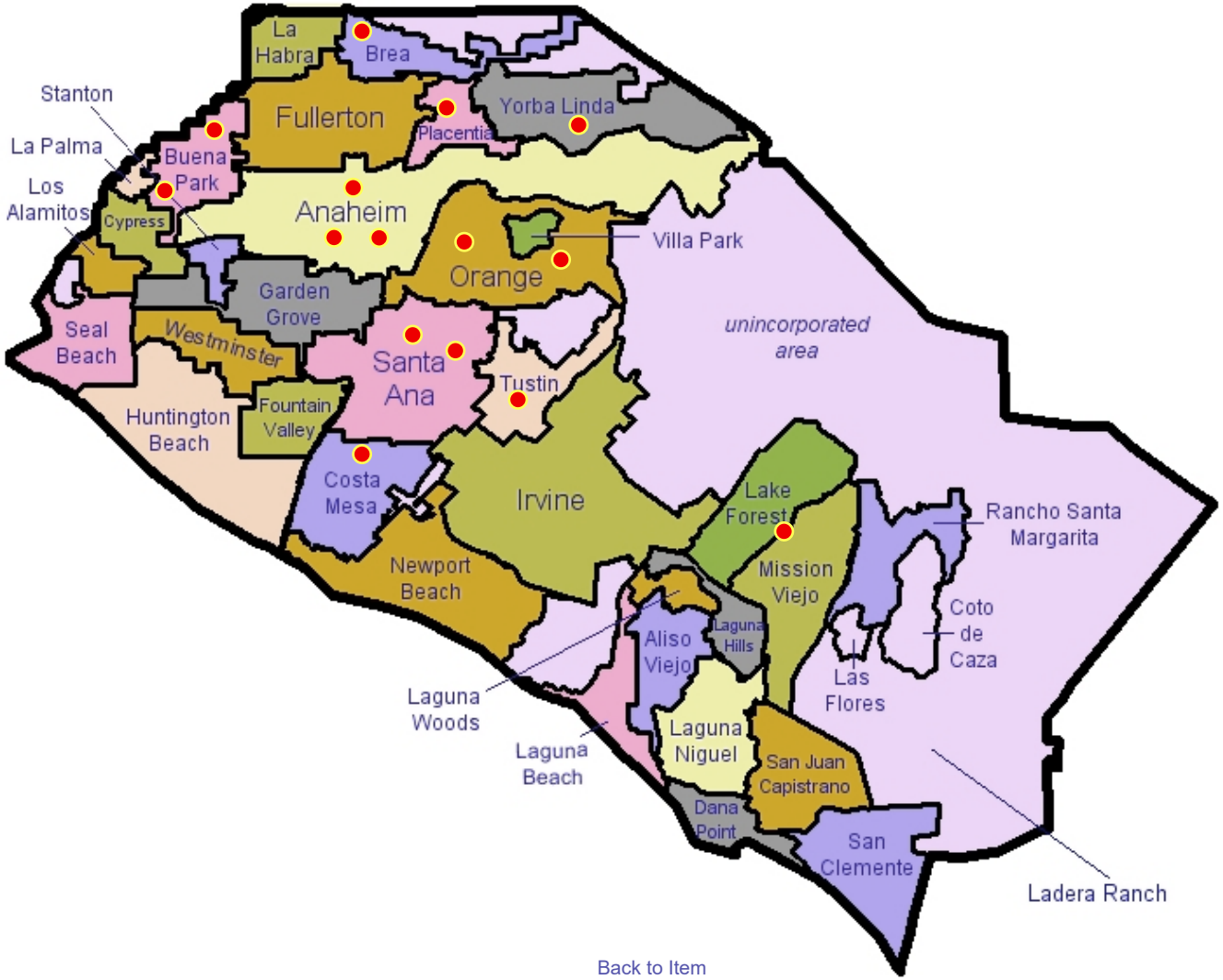
Back to Agenda

Capacity Grants

Organization Name	Total Funding Request	Funding Award	Number of Units	Brief Description
National Community Renaissance of California	$1,334,677	$1,334,677	65	The new (construction) community, Santa Angelina in Placentia, will provide 65 affordable apartment homes to seniors, 62+, who earn less than 60% of the area median income (AMI), with 34% designated for those who make less than 30% AMI. Twenty-one units are permanent supportive housing for unhoused seniors or seniors at-risk of becoming unhoused.
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	$1,400,000	$1,400,000	6	La Veta Village is a renovation of three historic homes in Orange alongside the construction of three accessory dwelling units. The six units will create 20 beds of affordable housing for families and seniors experiencing homelessness. Four units will be for families experiencing homelessness with at least one minor child, and two units will be for seniors experiencing homelessness over 62.
The Eli Home, Inc	$5,000,000	$5,000,000	11	Eli's housing project focuses on participants in CARP (Children of Addicts Recovery Program). Clients are recovering mothers who may also be victims of domestic violence, and their children who are victims of abuse and neglect. The new housing development in Anaheim will house mothers and their children who have completed CARP, have housing vouchers, and are ready to live in PSH. Participants are from extremely low to low-income.
WISEPlace	$1,000,000	$1,000,000	5	WISEPlace seeks to add five condos housing 24 unaccompanied women. Southern California Outreach has offered WISEPlace opportunity to purchase five units in Lake Forest and Mission Viejo with expired affordability restrictions. This project entails purchasing these units, preserving affordability restrictions, and rehabilitating. These units will be reserved for individuals earning no more than 50% AMI.
City of Brea	$8,000,000	$6,028,492	40	The proposed development is a new construction, permanent supportive housing project that will create 40 units designated for people experiencing homelessness earning at or below 30% AMI in the City of Brea. CES will also be utilized to place individuals into the units. They do have site/land control.

Back to Item
Back to Agenda

Project Locations



Back to Item

Back to Agenda

Next Steps

- Board COBAR prepared for October 5, 2023, meeting.
  - Will execute grant agreements during the month of October and will be effective by December 1st.
  - Check presentations to grantees at December board meeting.

- NOFO Round 3 anticipated to launch in Oct-Nov 2023 for additional equity grants and systems change grants.
  - Equity grants will be distributed to organizations not already receiving an equity or capacity building grant.
  - Systems change will be in response to specific program concepts.

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Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Approve Actions Related to the Street Medicine Program Expansion

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
1. Approve a notice of interest opportunity to identify two additional host-cities for the expansion of CalOptima Health's Street Medicine Program.
2. Approve the scope of work for the request for proposals (RFP) to identify additional providers to implement CalOptima Health's Street Medicine Program.

Background
On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of street medicine. On May 5, 2022, the Board approved the Street Medicine Program scope of work (SOW). On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare in Action to provide street medicine canvasing-based services. The pilot launched in Garden Grove on April 1, 2023.

As a means of addressing social determinants of health and health disparities, the California Department of Health Care Services (DHCS) has offered the opportunity for Medi-Cal managed care plans to earn Housing and Homelessness Incentive Program (HHIP) funds for making investments and progress in addressing homelessness and keeping people housed. CalOptima Health, in partnership with the Orange County Continuum of Care, submitted a Local Homelessness Plan to DHCS in June 2022. This plan included efforts to develop and implement CalOptima Health's Street Medicine Program. CalOptima Health reports to DHCS on progress toward this and other efforts to draw down additional incentive dollars. It is anticipated that CalOptima Health will receive this additional HHIP funding in March 2024.

Discussion
Street medicine includes health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. The fundamental approach of street medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. Working in collaboration with various county, city, and community organizations, street medicine's ultimate goal is to address and improve the overall health outcomes of the unsheltered, unhoused individuals served.

Since the April 1, 2023, launch of CalOptima's Street Medicine Program in the city of Garden Grove, 95 individuals experiencing homelessness have been enrolled and 100% of them are receiving primary medical care, including, but not limited to, ongoing medical care, ordering and reading labs, prescribed medications, referrals to specialists as needed and urgent care. In addition, 100% have voluntarily enrolled in California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management

Back to Agenda

and/or Community Support Services. Given the success of the Garden Grove pilot, CalOptima Health staff is requesting the Board's approval to expand its Street Medicine Program to two additional cities. To select the two additional cities in an equitable and transparent manner, CalOptima Health staff is requesting the Board approve a notice of interest opportunity. The notice of interest opportunity includes a series of attestations and questions, as well as requiring that a letter of support signed by the City Manager be uploaded into the application portal. *See* Attachment 1. With the Board's approval, the notice of interest opportunity will be launched by October 15, 2023, and close in November 2023. At that time, a committee of evaluators from CalOptima Health will review and score the submissions. CalOptima Health staff will return to the Board at the December meeting to request approval of the selected cities.

With the expansion to two additional cities comes the need for additional street medicine providers. Based on the success of the Garden Grove pilot, CalOptima Health Staff has updated the SOW to be used in the RFP to identify additional street medicine providers. CalOptima Health staff requests that the Board approve the updated SOW included as Attachment 2. With Board approval, the RFP will launch no later than December 2023. At closing, a committee of evaluators from CalOptima Health will review and score the submissions. CalOptima Staff will then return to the Board at the February 2024 meeting to request approval of the selected providers.

To fund CalOptima Health's Street Medicine Program expansion, CalOptima Health staff plans to use the remainder of the $8 million that the Board committed for street medicine in March 2022, and approximately $6 million in additional HHIP funds from DHCS that are anticipated for receipt in March 2024.

Fiscal Impact

The recommended actions have no additional fiscal impact. Staff will return to the Board to request funding allocations to align with the results of the notice of interest opportunity and RFP at future Board meetings.

Rationale for Recommendation

In order to engage CalOptima Health members experiencing homelessness where they are and on their own terms, to reduce or eliminate barriers to medical and social care, and with the success of CalOptima Health's Street Medicine Pilot Program operating in Garden Grove, CalOptima Health staff would like to expand its Street Medicine Program to two additional cities in 2024.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. CalOptima Health Notice of Interest Opportunity
2. CalOptima Health Street Medicine Program Scope or Work

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health:
Notice of Interest Opportunity for Street Medicine Expansion

CalOptima Health is accepting letters of interest from Orange County cities to expand its Street Medicine Program.

Application Deadline – November 8, 2023, 5 p.m. (PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. In line with that mission, CalOptima Health has made a commitment to address the health of our unsheltered members through our partnership-driven Street Medicine Program. Street medicine includes health and social services specifically developed to meet the unique needs and circumstances of unsheltered individuals. The fundamental approach of street medicine is to engage people experiencing homelessness where they are and on their own terms in order to maximally reduce or eliminate barriers to care and follow-through services. Working in collaboration with various county, city and community organizations, CalOptima Health's Street Medicine Program's ultimate goal is to improve the overall health and housing status of the unsheltered individuals served.

CalOptima Health's Street Medicine Program Values and Philosophies

CalOptima Health's Street Medicine Program is a critical piece of a larger, comprehensive approach to caring for our members living on the street and on their journey home. In addition to being able to provide important preventive services, urgent care and social services, this program fosters the relationship building that is key to helping a person into a permanent home. CalOptima Health's Street Medicine Program relies on three integrated components to achieve those health and housing outcomes: (1) Outreach and engagement, (2) coordinated medical care that meets people where they are, and (3) comprehensive Enhanced Care Management (ECM) and Community Supports.

The Street Medicine Program has a set of core values and philosophies that are recognized as best practices and, as research has demonstrated, drives the program toward success. First is the practice of

trauma-informed care, which includes the principles of safety, choice, collaboration, trustworthiness and empowerment. In practice, this entails meeting individuals where they are both literally and figuratively. Street medicine providers meet individuals in their identified home while showing the individual unconditional positive regard. The Street Medicine Program follows the philosophy of rapport first and care second, meaning the relationship the provider develops with those they serve is the foremost priority. Only once rapport is established can there be meaningful physical care. Similarly, the person must come first in street medicine, and being person-centered is a core philosophy of the program.

In addition to the above, utilizing a canvassing approach is crucial to street medicine. It goes hand in hand with meeting members where they are and takes some of the work, coordination and stress off the individual, as they do not have to navigate to a brick-and-mortar location. The street medicine providers canvas an identified geographical location to both enroll new individuals and provide comprehensive medical and social care, including ECM and Community Supports.

By ensuring the above philosophies and values are at the heart of the CalOptima Health Street Medicine Program, we are confident all selected street medicine providers can effectively treat the whole person and move them towards achieving the goals of the program.

Description of CalOptima Health's Street Medicine Program

The foundation of CalOptima Health's Street Medicine Program is two collaborative care teams, a coordination care team and a medical care team, that provide integrated outreach, engagement and comprehensive service provision. Collectively these teams engage in a canvassing-based approach to identify unsheltered members in the field and connect them to necessary preventive, urgent and primary care services. The coordination care team members are primarily responsible for identifying eligible members who agree to participate in the program and then providing services such as ECM, housing navigation (and additional housing-related Community Supports as applicable), routine face-to-face visits to address various medical needs and scheduling appointments with the medical care team. The medical care team is responsible for primary medical care including, but not limited to, ongoing medical care, ordering and reading labs, prescribing medications, and referrals to specialists and urgent care as needed. The medical care team offers all enrolled patients the opportunity to have the street medicine providers serve as their primary care provider (PCP). Together, these teams are designed to serve a caseload of up to 200 unsheltered members.

To ensure proper care and support for patients enrolled in the program, service provision standards have been established. For the medical care team, there is to be a minimum of one patient encounter with every person enrolled in the program every 45 days, with encounters varying depending on the acuity of medical needs. For the care coordination team, there is to be a minimum of one patient encounter with every person enrolled in the program per week. Services are more frequently provided based on each patient's specific needs.

CalOptima Health's Commitment

While CalOptima Health serves as the lead of our Street Medicine Program, we believe that a partnership-driven, collaborative effort between CalOptima Health and city personnel leads to the most effective and sustainable outcomes for our members living on the street.

In support of this partnership, CalOptima Health is committed to:

1. Delivering compassionate and dignified medical and social care to its unsheltered members to reduce barriers to quality medical and social care and improve the health outcomes of unsheltered individuals.
2. Collaborating with the selected cities to ensure seamless integration of its Street Medicine Program with consideration of the cities' broader endeavors to address homelessness.
3. Proactively engaging with the selected cities in the planning process and maintaining transparent communication throughout.
4. Inviting the selected cities to provide feedback on the top two provider proposals for their city.
5. Financially supporting the startup and launch of a street medicine team designed to serve a caseload of 200 unsheltered members.
6. Scheduling and chairing regular steering committee meetings and inviting all relevant stakeholders.
7. Closely supervising the providers to ensure the effective realization of the program's goals and objectives.
8. Providing routine outcome data to the cities based on the goals of CalOptima Health's Street Medicine Program.
9. Allocating space for the street medicine providers and the van on CalOptima Health property.
10. Remaining receptive to feedback from the cities pertaining to its Street Medicine Program.

City's Commitment

In support of this partnership, the selected city commits to:

1. Collaborating with CalOptima Health to welcome street medicine services within the city's jurisdiction, thereby supporting the compassionate and dignified treatment of its unsheltered residents in order to foster a sense of belonging within the community and improve their health outcomes.
2. Attesting their 2022 Point-in-Time Count showed a minimum of 200 sheltered and/or unsheltered individuals OR, alternatively, providing data proving such.
3. Formally recognizing CalOptima Health as the program lead and acting in support of CalOptima Health's Street Medicine Program framework.
4. Providing feedback in selecting a street medicine provider.
5. Collaborating with the provider CalOptima Health selects for service provision.
6. Sharing data on unhoused city residents with CalOptima Health, as appropriate or needed.

7. Actively participating in the planning and implementation of the Street Medicine Program by attending the Street Medicine Steering Committee meetings.
8. Ensuring that law enforcement and fire personnel actively engage in the collaborative efforts needed to effectively run the Street Medicine Program.
9. Allowing CalOptima Health's Street Medicine Program to serve all zip codes within the city's jurisdiction.
10. Assisting in locating properties within the city's jurisdiction that can serve as street medicine support centers in Phase II of CalOptima Health's Street Medicine Program.
11. Supporting the Street Medicine Program launch in their city no sooner than April 2024.

Evaluation Criteria

	Criterion	Maximum Points	Basis for Assigning Points
1.	CalOptima Health core value alignment, including commitment to treat individuals with dignity and respect	20	City's demonstrated commitment to trauma-informed, inclusive, person-centered programs and those that align with harm-reduction principles.
2.	Comprehensive, existing efforts and strategies to address homelessness	15	City must demonstrate experience and commitment to addressing the homelessness crisis.
3.	Existing partnerships and community involvement	15	City must describe existing partnerships that will positively contribute to the Street Medicine Program.
4.	Uploaded letter of interest	5	Application portal includes a letter of interest that must be signed by the city manager.
5.	All attestations complete	5	Application portal includes attestations that must be made regarding the Street Medicine Program.
Total Earnable Points		**60**	

Timeline

Activity	Date
Portal opens	Oct. 6, 2023, at 9 a.m.
Application deadline	Nov. 8, 2023, at 5 p.m.
Internal review	Nov. 9–22, 2023
CalOptima Health Board of Directors Meeting	Dec. 7, 2023

Documents and Portal Access

The letter of interest template, a series of qualitative questions, as well as the required city attestations will be made available on the following portal:

Questions about this opportunity? Contact Nicole Garcia, Director, Medi-Cal and CalAIM, at nicole.garcia@caloptima.org.

Notice of Interest Opportunity Application

Questions for the City

1. Does your city have a comprehensive strategy to address homelessness, and, if so, how are you implementing it?
2. What specialized services are available for unsheltered youth, veterans or families in your city?
3. Does your city have any shelters? If so, who operates them and how many beds?
4. How does your city collaborate with other municipalities, the County of Orange, local shelters, nonprofits or other non-governmental organizations to support the unsheltered population?
5. What role do law enforcement and fire personnel play in addressing homelessness?
6. Does your city have specific ordinances related to the unsheltered that could impact CalOptima Health's Street Medicine Program?

Attestations:

1. The city attests to its commitment to collaborate with CalOptima Health to welcome street medicine services within the city's jurisdiction, thereby supporting the compassionate and dignified treatment of its unsheltered residents in order to foster a sense of belonging within the community and improve their health outcomes.
2. The city hereby attests to having a minimum of 200 sheltered and/or unsheltered homeless people during the 2022 Point-in-Time Count. Alternatively, the city attests that it possesses verifiable data demonstrating the presence of a minimum of 200 sheltered or unsheltered homeless individuals currently residing within its jurisdiction.
3. The city attests to formally recognizing CalOptima Health as the program lead and acting in support of CalOptima Health's Street Medicine Program framework.
4. The city attests to its commitment to provide feedback in the process of selecting a street medicine provider.
5. The city attests to its willingness to collaborate with the provider selected by CalOptima Health for the provision of street medicine services.
6. The city attests to its willingness to share appropriate or needed data regarding unhoused residents with CalOptima Health.
7. The city attests to its active participation in the planning and implementation of CalOptima Health's Street Medicine Program, including attendance at Street Medicine Steering Committee meetings.
8. The city attests to ensuring active engagement of law enforcement and fire personnel in the collaborative efforts necessary for the effective operation of CalOptima Health's Street Medicine Program.
9. The city attests to granting permission for CalOptima Health's Street Medicine Program to serve all zip codes falling within the city's jurisdiction.

10. The city attests to its commitment to assist in identifying suitable properties that can function as a street medicine support center in Phase II of CalOptima Health's Street Medicine Program.
11. The city attests to the agreement that CalOptima Health's Street Medicine Program will commence no earlier than April 2024 within its jurisdiction.

Letter Upload on City Letterhead and Signed by the City Manager

Date

Michael Hunn
Chief Executive Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868

Subject: Letter of Interest — CalOptima Health Street Medicine Program

Dear Mr. Hunn,

I am writing on behalf of [City Name] to express our keen interest in collaborating with CalOptima Health as a host city for the expansion of CalOptima Health's Street Medicine Program in 2024.

We have reviewed and agreed to the attestations within the online platform for CalOptima Health's Street Medicine opportunity and this letter reflects our commitment to be a collaborative partner if our city were to be selected.

We recognize the importance of integrating our resources and expertise with your existing Street Medicine Program and our city is committed to addressing the health care needs of its unsheltered neighbors.

Sincerely,

[Name]
[City Manager]

Cc:

CalOptima Health Street Medicine Program
Scope of Work

I. OBJECTIVE

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value of the needs of each person. CalOptima Health is well-positioned to address its unsheltered member's health and housing with its partnership-driven Street Medicine Program. Street Medicine includes health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. The fundamental approach of Street Medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. Working in collaboration with various county, city, and community organizations, Street Medicine's ultimate goal is to address and improve the overall health outcomes of the unsheltered, unhoused individuals served.

II. SCOPE OF WORK BASICS

CalOptima Health's Street Medicine Program is a critical piece of a larger, comprehensive approach to caring for our neighbors living on the street and on their journey home. CalOptima Health's overall approach relies on three integrated components: (1) outreach and engagement; (2) coordinated medical care that meets people where they are; and (3) comprehensive ECM and Community Supports. Together, these components address acute health concerns and deploy integral preventative care, moving beyond stop-gap medical services to build the types of relationships that support a person's move home.

More specifically, CalOptima Health is looking for providers who can implement CalOptima Health's Street Medicine Program in an identified geographical service area, which will be dictated in the final Contract Agreement with CalOptima Health. It is understood that those experiencing homelessness can be transient in nature and services may sometimes be provided outside of city limits. The service area will be broken up into a number of zones. Zones will be determined with the knowledge from city officials as well as other community partners who are familiar with and serve within the boundaries of the defined service area. Each Coordination Care Team will be responsible for canvassing and providing services to the members found/enrolled in their zones. This will make for a more efficient use of time and resources and will promote consistency for the members enrolled in the program. The Medical Care Team will rotate throughout the zones in a routine fashion. Flexibility will be considered based on individuals' needs. Of note, it is understood that while staffing up a new location, fewer staff will likely be used to cover most of the geographical area of the program. As the program grows, more staff will be hired, and zones will be established.

Services will be provided in the field with a canvassing based approach by both Coordination Care Teams and Medical Care Teams. The Coordination Care Team members are responsible for providing ECM and Housing Navigation (and additional housing-related Community Supports, as applicable) to individuals who agree to participate in those services, routine face to face visits to address various needs of the members and scheduling appointments with the Medical Care Team. The Medical Care Team will be responsible for primary medical care including, but not limited to, ongoing medical care, ordering and reading labs, prescribing medications, referrals to specialists as needed and urgent care, as needed. The Medical Care Team will offer all enrolled patients the opportunity to serve as their Primary Care Physician (PCP). If interested, the Coordination Care Team will work with CalOptima Health to make arrangements. Of note, the patients care shall never take place in the street medicine provider's office location.

To ensure proper care and support of patients enrolled in the program, service provision standards have been established. For the Medical Care Team, who serves a patient panel of 200, there is to be a minimum of one patient encounter every 45 days, varying on acuity of medical need(s). For

Back to Item

Back to Agenda

the Care Coordination Team, who each carry 25 patients, there is to be a minimum of one patient encounter every week. Services will likely be provided more frequently based on each patient's specific needs. The Street Medicine Team members will work at the "top of their license" to ensure efficient and safe care is delivered to each patient. Further, the Team will regularly meet with CalOptima Health staff to discuss the program as well as other partners.

Note, providers are also expected to follow CalOptima Health's ECM Policy Guide and Community Supports Policy Guide, staffing requirements, documentation requirements meeting requirements and reporting requirements as established by CalOptima Health. Entities deemed qualified will be informed on and held to the standard of all of the above.

1. PRODUCTS/SERVICES

CalOptima Health's Street Medicine Program providers will ensure their staffing model meets the needs of the population served utilizing CalOptima Health Street Medicine Program standards.

Minimum staffing requirements for a street medicine team with a panel of 200 patients should include (but not be limited to):

a. A supervising Medical Doctor
b. One dedicated clinical provider such as Nurse Practitioner (NP), or Physician Assistant (PA), etc.
c. One clinical practitioner such as a nurse (RN/LVN)
d. One Project Manager
e. Two Care Management Team Supervisors
f. Eight Peer Navigators
g. One Mental Health Professional

Suite of medical services provided by Street Medicine provider, could include, but not be limited to:

a. Urgent care: acute infection, cough, UTI, etc.
b. Wound care
c. Vaccinations
d. Point of care testing (Urine dipstick [macroscopic urinalysis], urine hCG [pregnancy], whole blood creatinine, whole blood electrolytes, whole blood glucose, whole blood hemoglobin, COVID-19 antigen, sexually transmitted infections such as HIV/AIDS, syphilis, etc.)
e. Medication reconciliation and review
f. Prescription delivery (or able to prescribe for delivery)
g. Injectable anti-psychotics and other street psychiatry services
h. Age-appropriate health screenings
i. Chronic disease management
j. Referral to hospital on voluntary or 5150 basis
k. Primary care provider and specialist referral, as well as appointment scheduling, where applicable
l. Appropriate harm reduction methods, as needed, and in coordination with the Orange County Health Care Agency (e.g., Naloxone distribution, needle exchange, and medically assisted treatment, etc.)

Back to Item

Back to Agenda

2. PROVIDER'S RESPONSIBILITIES

CalOptima Health's Street Medicine Program providers are responsible for meeting the following criteria to ensure services are provided in the most effective manner possible:

a. Able to provide services to all individuals, regardless of CalOptima Health membership or health network affiliation or primary care assignment.
b. Maintain consistent recurring schedules and staff as established by CalOptima Health.
    1) Availability during both traditional and non-traditional hours, as well as potentially weekends/holidays, as identified in final contract.
    2) Be prepared to spend no less than 4 hours in the field on a given day.
c. Ability to serve as medical home/ primary care provider, as appropriate.
d. Provide CalAIM ECM and Community Support services to individuals enrolled in the program.
e. Have the necessary medical equipment to provide services on the street or in the mobile unit provided by CalOptima Health, including, but not limited to:
    1) Stethoscope
    2) Blood pressure cuff
    3) Pulse oximeter
    4) Wound care supplies
    5) Point of care testing supplies
    6) Frequently used medications for immediate dispensation: vaccines, insulin, diabetes medication, etc.
    7) Other medical supplies, as appropriate
f. Provide transportation for appointments at brick and mortar healthcare offices.
g. Make telehealth equipment available and provide services through this modality in a manner consistent with CalOptima Health's Policies and Procedures, meeting all regulatory requirements.
h. Develop clinical treatment protocols for specific conditions that can be treated in the street, to include post discharge planning and care transitions.
i. Able to refer to emergency room, medical respite or recuperative care.
j. Provide connection to housing by way of Homeless Management Information System (HMIS) and Coordinated Entry System (CES).
k. Develop materials (e.g., schedules, flyers, etc.), in collaboration with CalOptima Health, that can be shared publicly and with other service providers.
l. Submit claims using program specific billing guidelines and/or encounter tracking reports as developed by CalOptima Health and indicated in final contract agreement. Routinely reconcile claims reports.
m. Submit data as determined by CalOptima Health.

3. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health will evaluate capacity of each applicant to determine current state of infrastructure and information sharing capabilities, and will also be responsible for the following:

a. Educate the selected applicants on CalOptima Health's Street Medicine Program requirements.
b. Develop and maintain all program contracts, future policies and procedures, and any other documents required by DHCS or other regulatory entities.

c. Development of an incentive structure that enables providers to meet the requirements of the program.
d. Providing timely compensation and/or payment of associated incentives.
e. Support with development of materials, as noted above under Section 2h.
f. Train providers on documentation requirements and program-specific Billing Guidelines, as applicable.
    1) Includes provision of tools for data collection.
g. Member interpretation services will be provided by CalOptima Health, as is customary/standard practice for members.
h. Training for CalAIM Community Supports and Enhanced Care Management (ECM) to support continuity of care, including:
    1) Training and access to software or other programs such as SafetyNet Connect
i. Convene Street Medicine teams on a regular basis (frequency to be determined) to assess program needs and opportunities for improvement.
j. Provide Street Medicine Program van
k. Convene Steering Committee meetings with all necessary stakeholders, as needed.

4. DELIVERABLES

Prior to program start date indicated in final contract, participating providers are expected to have the necessary infrastructure in place (e.g., functional mobile units, medical supplies, technology, staff, etc.).

Street Medicine providers will be expected to meet the following deliverables throughout the course of the program:

a. Submit accurate and timely claims for CalOptima Health members following CalOptima Health's Billing Guidelines, within one month of service delivery.
b. Submit documentation, as defined in the final contract within the specified timeframe, in alignment with final incentive payment structure.
c. Submit accurate and timely data about the individuals being served by the program.
d. Tracking of unique and total contacts per day with notation of broad encounter outcomes using CalOptima Health programs and/or other tracking mechanisms.
    1) Type of clinical service to be document (e.g., primary care services, specialty care, etc.), and
    2) Documentation of other services (e.g., application assistance for non-clinical contacts) if provided by a partner in the field during the encounter.

5. PERFORMANCE GUARANTIES/MEASURES

Providers will be expected to submit all documentation within ten days after the end of the preceding month, in alignment with the final incentive payment structure and as defined in the grant agreement and contract.

III. ADDITIONAL AREAS TO CONSIDER

A. CULTURAL AND LINGUISTICS

Street Medicine providers will ensure that services are provided in a manner consistent with CalOptima Health policies and procedures. It is expected that the provider is able to provide documentation attesting staff or partners have received trauma-informed and recovery-centered training.

B. **MEMBERSHIP/ELIGIBILITY MANAGEMENT**

Individuals served must be experiencing sheltered or unsheltered homelessness. Complete definition that aligns with the Housing and Urban Development (HUD) definition as provided in Section 91.5 of Title 24 of the Code of Federal Regulation (CFR) is as follows:

a. An individual or family who lacks adequate nighttime residence
b. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation
c. An individual or family living in a shelter
d. An individual exiting an institution into homelessness
e. An individual or family who will imminently lose housing in next 30 days
f. Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes
g. Individuals fleeing domestic violence

IV. ADDITIONAL REQUIREMENTS

Provider must be able to implement CalOptima Health's Street Medicine Program Framework as described in Scope of Work (above).

1) Provider must be able to provide services to all individuals experiencing homelessness, regardless of CalOptima Health membership, and serve as medical home/primary care provider, as appropriate. Provide explanation on how you meet this.
2) Provider must be a credentialed Medi-Cal Provider and able to submit claims to CalOptima. Please confirm and provide Medi-Cal Provider number.
3) Provider must have completed documented trauma-informed care training, recovery-focused and person-centered training. Please describe how Company has completed these trainings and will continue to provide regular training in the areas described above.
4) Provider must meet the staffing requirements as specified above in the SOW. Please confirm the understanding.
5) Provider must be willing to provide services out of a mobile unit provided by CalOptima Health. Provide explanation on how this will be met.
6) Provider must be able to maintain consistent staff coverage on recurring schedules. Confirm and provide explanation on how this requirement will be met.
7) Provider must be able to provide connection to housing by way of providing CalAIM Enhanced Care Management and Community Supports, as well as enrollment in the CES and HMIS. Please identify if your organization is contracted as a CalAIM ECM and/or Housing Services provider. Please also identify if your agency currently is trained in and utilizes CES and HMIS.

V. Geographical Zone

A. Indicate below the areas in Orange County in which your organization is able to provide CalOptima Health Street Medicine services.

NORTH REGION	CENTRAL REGION	SOUTH REGION
☐Anaheim Brea	☐Costa Mesa	☐Aliso Viejo
☐Buena Park Cypress	☐Fountain Valley	☐Dana Point
☐Fullerton	☐Garden Grove	☐Irvine

Back to Item

Back to Agenda

☐La Habra
☐La Palma
☐Los Alamitos
☐Orange
☐Placentia
☐Stanton
☐Villa Park
☐Yorba Linda
☐County Unincorporated

☐Huntington Beach
☐Newport Beach
☐Santa Ana
☐Seal Beach
☐Tustin
☐Westminster
☐County Unincorporated

☐Laguna Beach
☐Laguna Hills
☐Laguna Niguel
☐Laguna Woods
☐Lake Forest
☐Mission Viejo
☐Rancho Santa Margarita
☐San Clemente
☐San Juan Capistrano
☐County Unincorporated

B. Describe any and all partnerships your organization currently has with the partners below within the geographic area(s) your organization identified above.

1. Homeless shelters/navigation centers
2. Other Street medicine programs or mobile clinics
3. Other organizations who serve the unsheltered
4. Recuperative care sites
5. Post-hospitalization housing
6. Hospitals
7. Emergency Personnel
8. Be Well
9. County of Orange Health Care Agency, including Outreach & Engagement

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken October 5, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
16. Approve Amendments to Hospital Services Contract with Kindred Hospitals

Contacts
Yunkyung Kim, Chief Operating Officer (714) 246-8408
Michael Gomez, Executive Director, Network Operations (714) 347-3292

Recommended Actions
1. Authorize the Chief Executive Officer to amend CalOptima Health's Hospital Services Contracts with Kindred Hospitals (Kindred) to update reimbursement rates and contract terms for Medi-Cal, effective October 5, 2023.
2. Authorize unbudgeted expenditures in an amount up to $650,000 from existing reserves to fund the increase to reimbursement rates for Medi-Cal Kindred Hospital Services Contracts through June 30, 2024.

Background and Discussion
Staff requests Board approval of the proposed amendments to CalOptima Health's Hospital Services Contracts with Kindred, which includes agreements for the following four Kindred facilities:
- THC – Orange County, Inc. dba Kindred Hospital – Brea
- THC – Orange County, Inc. dba Kindred Hospital – Westminster
- Southern California Specialty Care, Inc., dba Kindred Hospital -La Mirada
- Southern California Specialty Care, Inc., dba Kindred Hospital -Santa Ana

CalOptima Health has been contracted with Kindred since 2007 on a fee-for-service basis for provision of Long-Term Acute Care (LTAC) services for Medi-Cal, OneCare, and most recently, Program of All-Inclusive Care for the Elderly (PACE) members. Kindred is a fully functional acute care hospital licensed to treat persons who have typically been treated in an intensive care unit (ICU) and who require post-acute care in an extended hospital inpatient setting, daily doctors' visits, and 24 hour respiratory and nursing care to help persons fully recover. Generally, the hospital stay in a LTAC is approximately 25 days compared to a short-term acute care hospital stay that is generally 5-7 days. As the sole LTAC service provider in Orange County, Kindred treats complex members requiring LTAC services. Kindred has a total of 329 beds across its four facilities, with a total of 15 CalOptima Health members currently admitted between them all.

CalOptima Health's agreements with Kindred are set to expire on November 6, 2023. In the absence of its contracts with Kindred, CalOptima Health would be required to direct CalOptima Health members outside of Orange County and enter letters of agreements on a case-by-case basis with LTAC facilities in Los Angeles and San Diego counties. Given Kindred's vital role in serving CalOptima Health's members and the community in general, staff proposes the attached amendment providing for the following updates to CalOptima Health's agreements with Kindred:

Back to Agenda

1) Renewal of the contract term to reflect an effective date of October 5, 2023 through September 30, 2026, with five (5) additional one-year (1) automatic extensions, except as otherwise directed by the Board.
2) An increase to per diem Medi-Cal reimbursement rate for inpatient admissions with no changes to reimbursement for outpatient services.
3) Carve out reimbursement for dialysis services from the inpatient per diem payment.

To ensure access to care for CalOptima Health members requiring LTAC services and stability of CalOptima Health's acute care hospital network for Medi-Cal, OneCare, and PACE members, staff requests approval of the proposed amendment to Kindred's Hospital Services Contracts.

Fiscal Impact
The recommended action to update reimbursement rates with Kindred Hospitals for the Medi-Cal line of business has an estimated annual fiscal impact of $860,000 or 7.6%. An appropriation of approximately $650,000 in existing reserves will fund the unbudgeted net expense for the nine (9) month period of October 5, 2023, through June 30, 2024. Staff will include updated medical expenses in future operating budgets.

Rationale for Recommendation
Without contracted LTAC providers in CalOptima Health's provider network, CalOptima Health's contracted short-term acute care hospitals would be negatively impacted by a significant increase in long-term care patient stays, reducing access to acute care beds for CalOptima Health members. This amendment will preserve access to LTAC services as well as the stability of CalOptima Health's acute care hospital network in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Draft Contract Amendment

Board Actions
N/A

/s/ Michael Hunn *09/29/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
THC – Orange County LLC, dba Kindred Hospital Brea	875 N. Brea Blvd.	Brea	CA	92821
THC – Orange County LLC, dba Kindred Hospital Westminster	200 Hospital Circle	Westminster	CA	92683
Southern California Specialty Care LLC dba Kindred Hospital – La Mirada	14900 E. Imperial Hwy.	La Mirada	CA	90638
Southern California Specialty Care LLC dba Kindred Hospital – Santa Ana	1901 N. College Ave.	Santa Ana	CA	92706

Back to Item

Back to Agenda

AMENDMENT #__ TO
HOSPITAL SERVICES CONTRACT

THIS AMENDMENT #__ TO THE AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT ("Amendment") is effective as of October ____, 2023 through September 30, 2026, by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("CalOptima"), and _____ ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract ("Contract"), as amended, by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree to the following amendments to the Contract:

1. Delete Section 7.1 of the Contract in its entirety and replace with the following new Section 7.1:

   "7.1 Term. The term of this Contract shall become effective on October ___, 2023 and continue in effect through September 30, 2026 and five (5) additional one-year automatic extensions except as directed otherwise by the Board."

2. Attachment B, "Compensation", is deleted in its entirety and replaced with the attached Attachment B – Amendment #__, "Compensation".

3. Attachment B-1, "Medi-Cal Compensation Rates for Adult Expansion Members" shall be deleted in its entirety.

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	Yunkyung Kim
Print Name	Print Name
_____	Chief Operating Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT B – AMENDMENT #__

COMPENSATION RATES

For Covered Services provided to CalOptima Members under this Contract, CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts:

I. Medi-Cal
(Includes Medi-Cal Expansion Members)

Inpatient Services

Inpatient Services are payable under this contract at two different levels of service, as follows:

A. **Long Term Acute Care (LTAC)**

Inpatient days meeting LTAC clinical criteria for all days that are prior authorized by CalOptima.

B. **Administrative Days**

California Code of Regulations, Title 22, Section 51173 describes acute administrative days (AAD) as those days approved in an acute inpatient facility which provides a higher level of medical care than that currently needed by the patient.

Inpatient Rates

In accordance with the above designations, authorized services will be paid in accordance with the table below. No amounts are payable for any days for which prior authorization at one of the above levels of service has not been obtained.

Hospital Services	Revenue Codes	Per Diem Reimbursement
LTAC	100-101, 110-113, 117, 119-123, 127, 129-133, 137, 139-143, 147, 149-153, 157, 159-160, 164, 167, 200-219	
Administrative Days	169	
Dialysis (in addition to above per diem rates)	800, 801, 802, 803, 804, 809	

Other Services

Other Services	Revenue Codes	Per Diem Reimbursement
High Cost Exclusion Items	Refer to High Cost Exclusion Payment Policy	

Excluded Items: Excluded items shall be reimbursed in accordance with CalOptima Policy.

Inpatient admissions to the hospital prior to the effective date of any rate amendment and where the Member is still inpatient on the date of this amendment, shall be paid at the rates in place at the time of admission for the entire length of the stay.

When a member no longer meets the criteria for an LTAC inpatient stay, the Hospital may request administrative days. CalOptima shall reimburse approved Administrative Days at the rates as outlined in Attachment B, Compensation of this Amendment. If the administrative day authorizations exceed length of administrative days beyond 30 days, both parties agree to work in good faith to reduce administrative day utilization. After the initial 3-year term, as defined in Section 7.1, if Hospital demonstrates to CalOptima that the administrative days have accounted for greater than 10% of CalOptima's average total inpatient days over three-year period, CalOptima shall review the administrative day level of reimbursement to determine if adjustments to the administrative day level reimbursement is appropriate. Upon mutual agreement between the parties, a new administrative day level of reimbursement shall be effective after the end of the 3-year term and effectuated by an amendment executed by the parties.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

Outpatient Services

- Outpatient services (excluding drugs) shall be reimbursed at ____ of Medi-Cal reimbursement rates.
- Outpatient administered drugs shall be reimbursed at ____ of Medi-Cal reimbursement rates.
- Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

Billing and reimbursement will be in accordance with Medi-Cal payment guidelines.

II. Medicare Advantage (OneCare)

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to Medicare billing guidelines	

Outpatient Services

- Outpatient services shall be reimbursed at ___ of Medicare Allowable Rates.

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Excluded from the per diem rates are the items identified in this footnote. For such items, Hospital shall submit a Hospital generated invoice to be accompanied with billing, and CalOptima shall pay ___ of Hospital's discounted cost for such excluded items, which cost must be supported by original invoices on file at Hospital with the appropriate discount(s) noted. The excluded items are:

   - Implants including, but not limited to Pacemakers, AICDs, Stents, Radioactive Seeds, Leads
   - Prosthetics & Orthotics
   - Valves, Shunts and Grafts
   - High Cost pharmacy in excess of $500 cost/unit

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.

III. PACE

Hospital Services	Revenue Codes	Per Diem Reimbursement
Inpatient Services – LTAC level of care	Refer to Medicare billing guidelines	

Outpatient Services

- Outpatient services shall be reimbursed at ___ of Medicare Allowable Rates.

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Footnotes:

1. For Medicare Part A or Part B services provided to CalOptima Medicare Advantage Enrollee Patients, Hospital's compensation shall equal the applicable rate shown on this Attachment B.

2. Excluded from the per diem rates are the items identified in this footnote. For such items, Hospital shall submit a Hospital generated invoice to be accompanied with billing, and CalOptima shall pay ___ of Hospital's discounted cost for such excluded items, which cost must be supported by

original invoices on file at Hospital with the appropriate discount(s) noted. The excluded items are:

- Implants including, but not limited to Pacemakers, AICDs, Stents, Radioactive Seeds, Leads
- Prosthetics & Orthotics
- Valves, Shunts and Grafts
- High Cost pharmacy in excess of $500 cost/unit

3. All physician fees are excluded.

4. In the event of a contracted rate change, the rate in place at the time of admission is the rate that shall be paid.