CalOptima Health

It Has Accumulated Excessive Surplus Funds and Made Questionable Hiring Decisions

May 2023

REPORT 2022-112

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May 2, 2023
2022-112

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of certain aspects of the budget, services and programs, and organizational changes of the Orange County Health Authority, referred to as CalOptima Health (CalOptima). CalOptima is the sole Medi-Cal managed care plan in Orange County and serves nearly one million members. We determined that CalOptima accumulated surplus funds it should have used to improve services, retained a larger share of funds obtained through a process known as intergovernmental transfer (IGT) than other managed care plans we reviewed, and did not follow best practices when hiring for some executive positions.

CalOptima had accumulated more than $1.2 billion in unrestricted funds as of June 2022. It set aside $570 million of these funds as a reserve, which we determined was prudent, but the remaining $675 million represent surplus funds. An Orange County ordinance requires CalOptima to implement a financial plan that provides for using surplus funds on specific purposes, such as improving benefits, but CalOptima does not have a plan for spending all of its surplus funds and has struggled to use them in a timely manner. CalOptima also retained a larger share of IGT funds than other managed care plans we reviewed. Although it allocated a significant portion of its retained IGT funds for health care initiatives focused on members experiencing homelessness, it did not consistently monitor the effective use of those funds.

CalOptima's executive turnover rate was higher than those of other managed care plans we reviewed, and it has hired several executives in recent years. However, it did not follow best practices when hiring three of six executives we reviewed, and one of its former board members may have violated state law when he entered into an employment contract to serve as the organization's chief executive officer. CalOptima lacked a written policy that could have guided its approach to hiring in these instances. As a result of its practices, CalOptima has limited its ability to attract and select the most qualified candidates, and it has opened itself to criticism about the objectivity, appropriateness, and transparency of its hiring process.

Respectfully submitted,

GRANT PARKS
California State Auditor

Selected Abbreviations Used in This Report

CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CRDD	Capitated Rates Development Division
DHCS	Department of Health Care Services
GFOA	Government Finance Officers Association
HHI	Homeless Health Initiatives
HR	human resources
IGT	intergovernmental transfer

Contents

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Summary

California participates in the federal Medicaid program through its California Medical Assistance Program, known as *Medi-Cal*. In Orange County, the Orange County Health Authority, referred to as CalOptima Health (CalOptima), is the sole Medi-Cal managed care plan and serves nearly one million members, the majority of whom are beneficiaries of Medi-Cal. CalOptima's funding comes primarily from the Department of Health Care Services (DHCS), which makes monthly payments to CalOptima based on per-member rates for the provision of covered services. A process known as *intergovernmental transfer* (IGT) allows DHCS to increase the rates paid to managed care plans like CalOptima using federal matching funds. The IGT process involves a partnership between managed care plans and other government entities (funding partners). CalOptima's board of directors (board) directed it to implement this IGT process in 2011. Since then, CalOptima has continued to use the IGT process, and it currently has five funding partners.

CalOptima Has Accumulated Surplus Funds It Should Have Used to Improve Services

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As of June 2022, CalOptima had accumulated more than $1.2 billion in unrestricted funds. An Orange County ordinance requires CalOptima to implement a financial plan that includes the creation of a prudent reserve and provides that if surplus funds accrue they shall be used for specified purposes such as improving benefits. CalOptima's board designated an amount for its reserve that is consistent with an established practice for government reserves, and CalOptima has set aside sufficient funds to meet the board's requirements. However, beyond satisfying this reserve requirement, CalOptima had accumulated an additional $675 million of surplus funds as of June 2022. Notwithstanding the requirements in the Orange County ordinance, CalOptima's reserve policy does not specify what it will do with such surplus funds, and it has struggled to spend them in a timely manner.

Our recommendations for improving this area of CalOptima's operations are on page 14.

CalOptima Retained a Larger Share of IGT Funds Than Other Managed Care Plans

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Until recently, CalOptima retained approximately 30 percent of IGT funds, substantially more than the percentages agreed to by other managed care plans we reviewed and their funding partners. As of June 2022, CalOptima held $90 million in unused IGT funds. CalOptima allocated a significant portion of IGT funds for health care initiatives focused on members experiencing homelessness, but it did not consistently monitor the effective use of those funds.

Our recommendation for improving this area of CalOptima's operations is on page 22.

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CalOptima Did Not Follow Best Practices When Hiring for Some Executive Positions

A former CalOptima board member may have violated a state law that prohibits public officials from being financially interested in certain contracts when he entered into an employment contract with CalOptima to serve as its chief executive officer (CEO). In addition, CalOptima does not have a written policy describing its hiring process. CalOptima hired a significant number of new executives in recent years, but for three of the six executives we reviewed, it did not follow the hiring process its human resources department described to us, and in some instances its actions were not consistent with its publicly stated plans for hiring executives. For example, it did not conduct national searches for two consecutive CEOs, as it said it would. By not doing so, CalOptima's board limited its ability to attract and select the most qualified candidates and opened itself to criticism about the objectivity, transparency, and appropriateness of its hiring process.

Our recommendations for improving this area of CalOptima's operations are on page 28.

Other Areas We Reviewed

We also reviewed other areas of CalOptima's operations, including its efforts to investigate reports of misconduct and ensure an atmosphere free from fear of retaliation, the actions it has taken to ensure timely access to care, and the accessibility of financial information on its website.

Our recommendations for improving one of these areas of CalOptima's operations are on page 31.

Agency Response

CalOptima stated that it cannot fully concur with all of our findings and recommendations because the time frame of the audit does not account for recent leadership actions over the past year. It also stated that it has already rectified many of the changes recommended in the audit, and it concurred or partially concurred with each of the individual findings.

We did not make recommendations to address findings that CalOptima demonstrated it had already resolved, as we explain in our comments on CalOptima's response to our report that begin on page 49.

Introduction

Background

The federal Medicaid program, which the Centers for Medicare & Medicaid Services (CMS) oversees, provides medical assistance to certain low-income individuals and families who meet eligibility requirements. California participates in the federal Medicaid program through its California Medical Assistance Program, known as *Medi-Cal*. California's Department of Health Care Services (DHCS) is the state agency responsible for administering Medi-Cal, and state law identifies county welfare departments as the agencies responsible for Medi-Cal's local administration.

In 1993 Orange County created the Orange County Health Authority, referred to as *CalOptima Health* (CalOptima), and it is the sole Medi-Cal managed care plan in Orange County. A managed care plan is a health care delivery system, such as a health maintenance organization, that typically receives a flat prepaid rate for each member enrolled in the plan and provides services to those members through a defined network of health care providers. As established in Orange County ordinance, CalOptima's purpose is to negotiate exclusive contracts with DHCS and arrange for the provision of health care services to qualifying individuals in the county who lack sufficient annual income to meet the cost of health care. Its stated mission is "to serve member health with excellence and dignity, respecting the value and needs of each person." Governance of CalOptima is vested in a board of directors (board) consisting of 10 individuals who are each required to have a commitment to a health care system that seeks to improve access to high-quality health care for those CalOptima serves. As the text box shows, nearly all of CalOptima's members are Medi-Cal beneficiaries. CalOptima offers additional programs that serve a smaller number of members who qualify for both Medi-Cal and Medicare.

Key Facts About CalOptima (October 2022)

Fiscal year 2022–23 budgeted revenue	$4 billion
Fiscal year 2022–23 budgeted expenses	$4 billion
Total number of members	938,000
Number of Medi-Cal members	920,000
Number of employees	1,500
Provider network	1,500 primary care physicians 9,200 specialists

Source: CalOptima's website and budget documents.

Funding for Medi-Cal

Both the federal and state governments fund the costs of Medi-Cal. As a Medi-Cal managed care plan (managed care plan), CalOptima's revenue is primarily provided by DHCS, as Table 1 details, in the form of payments that include money from both state and federal sources. DHCS data indicate that, on average, about 30 percent of the funds that DHCS paid to CalOptima during the period we reviewed were provided by the State and 70 percent were provided by the federal government.[1] CalOptima was not able to confirm these amounts. CalOptima's controller stated

[1] Although it was not possible to fully reconcile DHCS's data to CalOptima's financial statements, the difference is less than 3 percent of the proportion of state or federal funds. In addition to this difference, according to the chief of DHCS's Capitated Rates Development Division, the data do not reflect all of the payments that DHCS will eventually make for these periods, especially for more recent fiscal years. He also stated that the data do not reflect rate revisions that are in the process of being made, system updates that will affect the split of federal and state funding, or some adjustments to payments that are processed outside of this system.

that he is unable to say how much of the funding CalOptima receives from DHCS is state funding and how much is federal funding. This is likely because, according to the assistant chief of DHCS's Capitated Rates Development Division (CRDD assistant chief), DHCS does not distinguish for the plan what portion of the payments is from state funds and what portion is from federal funds. Table 1 also shows the amount of funds CalOptima received from CMS. Those funds were for the additional programs serving a smaller number of members who qualify for both Medi-Cal and Medicare that we mention above.

Table 1
Most of CalOptima's Revenue Is Received in the Form of Combined State and Federal Funds

CALOPTIMA FUNDING SOURCES	FISCAL YEAR 2019–20	FISCAL YEAR 2020–21	FISCAL YEAR 2021–22	FISCAL YEAR 2022–23
State and Federal Funds Received From State Agencies (DHCS)*	$3.521 billion **(92%)**	$3.804 billion **(92%)**	$3.865 billion† **(91%)**	$3.652 billion† **(91%)**
Federal Funds Received From a Federal Agency (CMS)	312 million **(8%)**	344 million **(8%)**	360 million **(9%)**	350 million **(9%)**
Private Funds	‡	‡	None	None
Totals	**$3.833 billion**	**$4.148 billion**	**$4.225 billion**	**$4.002 billion**

Source: CalOptima's audited financial statements for fiscal years 2019–20 through 2021–22, CalOptima's fiscal year 2022–23 budget, and interviews with CalOptima and DHCS staff.

* When DHCS pays a managed care plan such as CalOptima, DHCS does not distinguish for the plan what portion of the payment is from state funds and what portion is from federal funds.

† Less than 0.1 percent of these funds are provided by the California Department of Aging.

‡ CalOptima received a small amount of member funds (less than $7,000).

In accordance with the contract between CalOptima and DHCS, DHCS makes monthly payments to CalOptima on behalf of each Medi-Cal member. DHCS makes these payments in amounts that are based on per-member rates for the provision of covered services (rates). DHCS can also establish an upper and lower limit (rate range) for the rates. For example, the rate range for DHCS's monthly payments to CalOptima for an adult member from January through December 2022 was from $246 to $262 approximately. According to the CRDD assistant chief, DHCS typically sets base rates for managed care plans at or near the lower limit of the rate range. If plans participate in the process that we describe below, however, he said that DHCS has paid up to the upper limit of the range. Then, according to CalOptima's chief operating officer, CalOptima contracts with providers of Medi-Cal services at negotiated rates to provide services to its members.

To enable managed care plans to compensate providers of Medi-Cal health care services and to support the Medi-Cal program, state law allows DHCS to operate the Voluntary Rate Range Program. Under this program, DHCS may increase the rates paid to managed care plans like CalOptima from the lower limit of the rate range to the upper limit of the rate range. Through the program, DHCS may accept what is known

as an intergovernmental transfer (IGT). DHCS then obtains federal matching funds to the full extent permitted under federal law. This report refers to the process DHCS administers under its Voluntary Rate Range Program as the *IGT process*.

The IGT process involves a partnership between managed care plans and participating government entities (funding partners). To begin this process, DHCS requests proposals from managed care plans to participate in the IGT process, and it requires the plans to contact potential funding partners to determine their interest in and desired level of participation in the IGT process. Through the IGT process, which Figure 1 depicts, the interested funding partners voluntarily transfer funds to DHCS (IGT contribution). State law specifies that DHCS is generally required to assess an additional 20 percent fee on the value of a funding partner's IGT contribution to reimburse DHCS for administering the IGT process and for support of the Medi-Cal program.

DHCS then obtains federal matching funds based on the amount of the funding partners' IGT contributions, and it pays the total amount of the IGT contributions and federal matching funds (IGT funds) to managed care plans. It does so by increasing the rates within the established rate range and paying the IGT funds as part of the rates it pays to managed care plans for Medi-Cal services. The IGT process thus results in more revenue available to pay for the costs of Medi-Cal services. The funding partners that participate in the IGT process may receive IGT payments for services they provide themselves, or they may designate a provider to receive the IGT payments.

CalOptima's board directed it to implement the IGT process in 2011. At that time, CalOptima anticipated expanding its Medi-Cal membership as a result of early implementation of components of the federal Patient Protection and Affordable Care Act (Affordable Care Act). Under the Affordable Care Act, eligibility for Medi-Cal expanded to include nearly all non-elderly adults with incomes at or below 133 percent of the federal poverty level. CalOptima identified that the IGT process could generate matching funds needed to leverage federal funding for members added through this expansion (expansion members), and its board approved entering into an agreement with the University of California Irvine Medical Center as its initial funding partner in the IGT process.

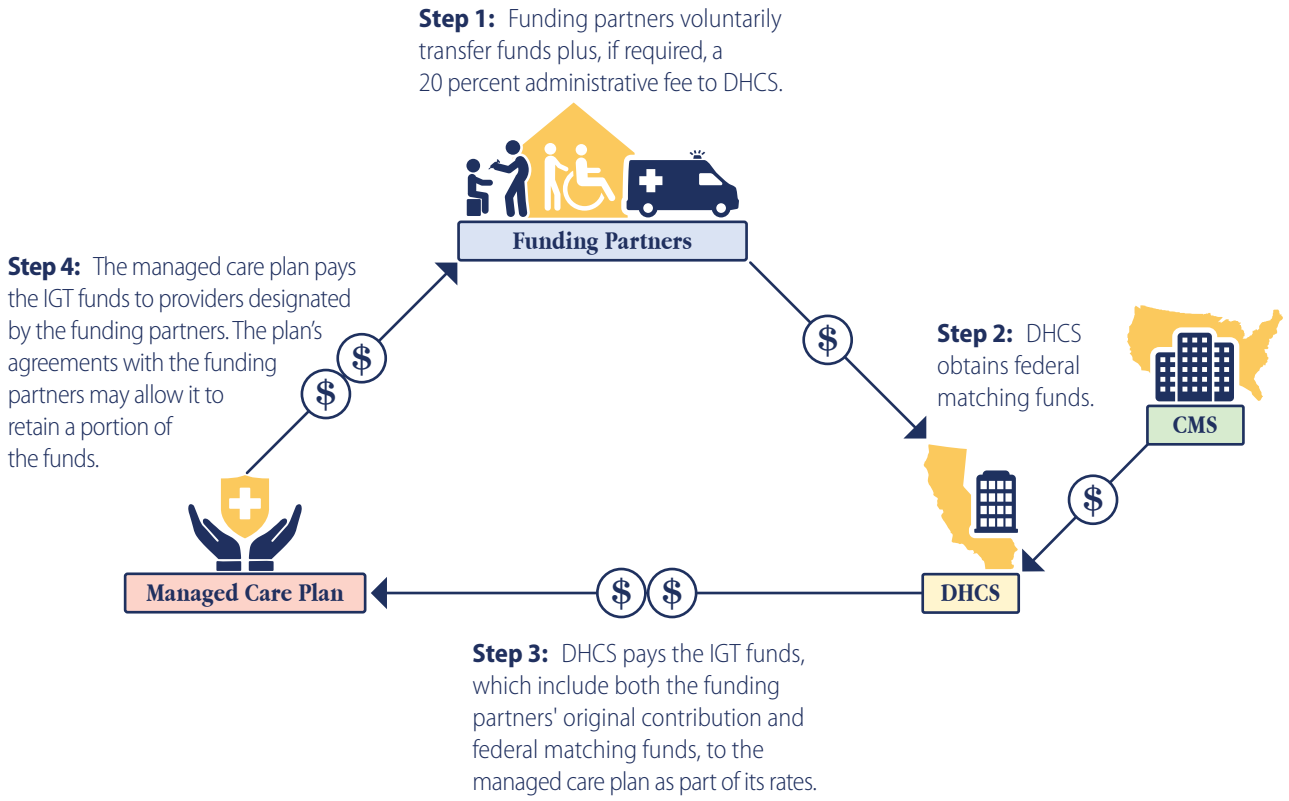
Since then, CalOptima has continued to use the IGT process, and additional funding partners have elected to participate in the process. State law allows a broad range of government entities to elect to participate in the IGT process and transfer funds in support of Medi-Cal. The text box shows CalOptima's five current funding partners.

CalOptima's IGT Funding Partners as of December 2022

- University of California Irvine Medical Center
- First 5 Orange County, Children and Families Commission
- County of Orange Health Care Agency
- City of Orange Fire Department
- City of Newport Beach Fire Department

Source: CalOptima board meeting agenda materials, CalOptima correspondence, funding partners' websites, and interviews with CalOptima staff.

Figure 1
The IGT Process Provides Increased Funding to Pay for Medi-Cal Costs



Amounts Paid and Received by Each Party for a $100 Contribution to the IGT Process*

ENTITY		AMOUNT PAID IN	AMOUNT RECEIVED
Funding Partners	Contribution	$100	$198
	Administrative Fee	20	
DHCS			20
CMS	Matching Funds	100	
Managed Care Plan			2
	Totals	**$220**	**$220**

Source: State law, IGT contracts and agreements, and DHCS internal correspondence.

* Assumes a 1:1 federal match and a managed care plan retention rate of 2 percent.

CalOptima Has Accumulated Surplus Funds It Should Have Used to Improve Services

Key Points

- CalOptima accumulated surplus funds of $675 million in excess of its designated reserves instead of spending those surplus funds as county ordinance specifies.
- CalOptima's reserve policy was consistent with recommended practices and was similar to the policies of other managed care plans we reviewed, but its surplus funds exceeded the reserve amount set in policy by a greater degree than we observed at similar entities.

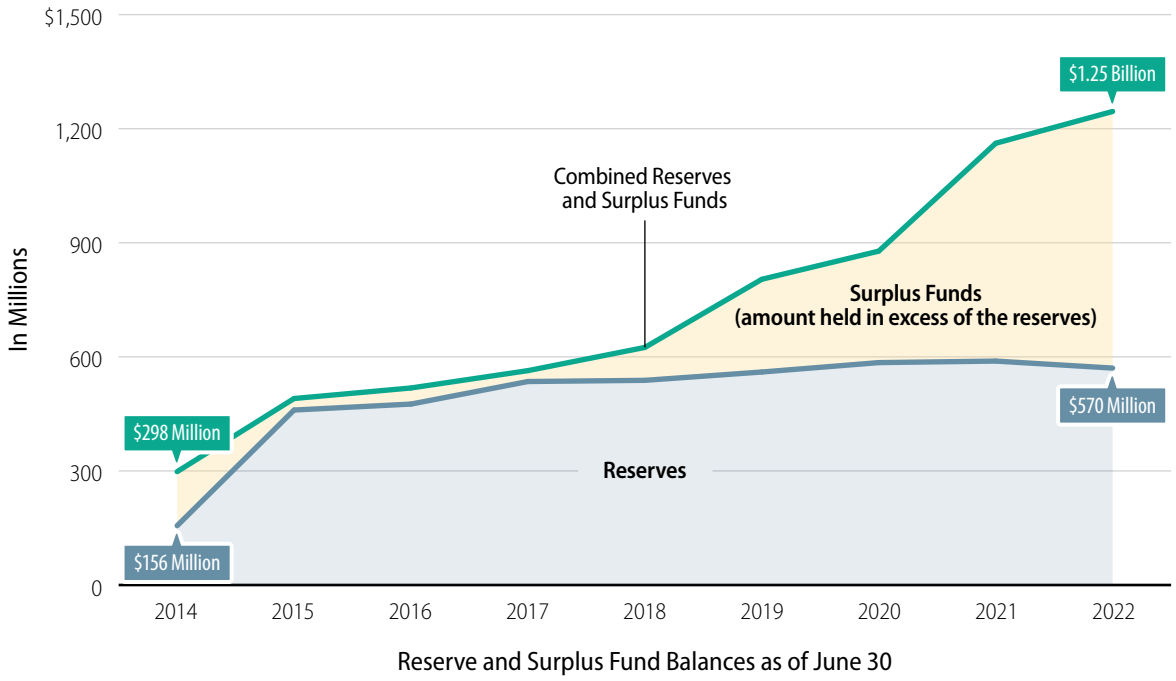
As of June 2022, CalOptima's Surplus Funds Exceeded the Amount of Its Designated Reserves by $675 Million

The Orange County ordinance that created CalOptima requires it to implement a financial plan that includes the creation of a prudent reserve. The reserve policy that CalOptima's board adopted specifies that it maintain board-designated reserves of no less than 1.4 months and no more than 2.0 months of certain revenues, which is similar to financial practices recommended by the Government Finance Officers Association (GFOA). CalOptima's audited financial statements describe the funds it has set aside for these reserves as its board-designated assets. Throughout this report, we present the amount of these funds as CalOptima's *reserves*, as CalOptima has stated in various public and board documents. As of June 30, 2022, CalOptima had accumulated more than $1.2 billion of combined reserves and surplus funds—with the surplus being unrestricted funds available for CalOptima's use that are in excess of its reserves. However, the $675 million in surplus funds should have been used to improve services.

From 2014 to 2022, CalOptima's reserves increased from $156 million to $570 million, as Figure 2 shows, in part because its membership increased by nearly 50 percent and its revenues increased by a larger proportion—more than 110 percent. However, during the same period, CalOptima's surplus funds increased by an even larger amount, from $142 million to $675 million. In total, these reserves and surplus funds are equal to 3.5 months of CalOptima's revenues.

State law requires CalOptima and most managed care plans to maintain a minimum level of financial equity, and contracts between DHCS and managed care plans to provide Medi-Cal services also require the managed care plans to maintain that amount of financial equity. However, this amount may not be enough to meet the plans' needs in the event of unforeseen circumstances. In CalOptima's case, the amount of financial equity required was equal to less than 10 days of revenues as of June 2022. By contrast, the GFOA recommends that governments maintain reserves equal to no less than two months of their annual revenue or expenditures. Thus, CalOptima's decision to establish a policy with a reserve level higher than the minimum amount of financial equity that state law and its contract with DHCS require was a prudent choice.

Figure 2
CalOptima's Surplus Funds Have Significantly Exceeded Its Reserves for Several Years



Source: CalOptima's audited financial statements for fiscal years 2013–14 through 2021–22.

Note: We obtained the amounts for CalOptima's reserves from its audited financial statements. To calculate the amount of surplus funds for each year, we subtracted the amount of its reserves from the amount of its unrestricted net position.

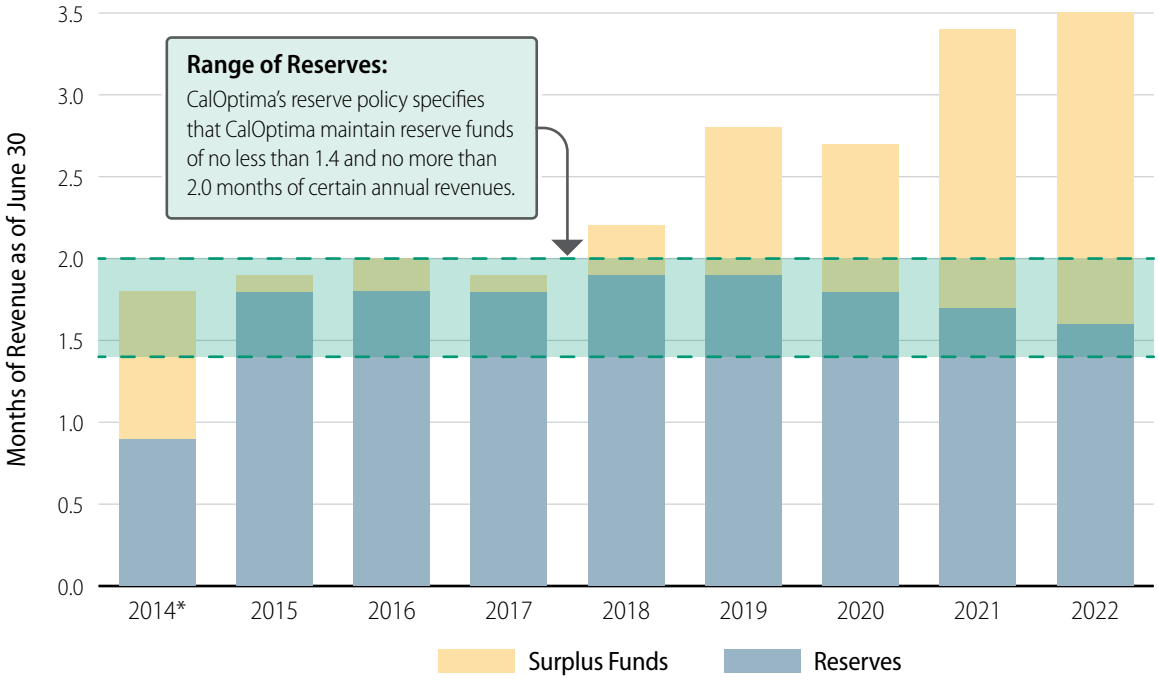
According to CalOptima's chief financial officer (CFO)—who began her current tenure at CalOptima in 2014 and her current position in 2019—the board-designated reserve level is sufficient to meet regulatory requirements and to allow CalOptima to meet its obligations in the event of unexpected circumstances. Therefore, CalOptima does not appear to need a larger reserve.

Although CalOptima has maintained reserves that satisfy the requirements in county ordinance, it has not complied with other elements of county ordinance regarding its use of surplus funds that are in excess of its reserve. The Orange County ordinance that requires CalOptima to implement a financial plan including a prudent reserve also requires the financial plan to provide that if additional surplus funds accrue, those additional funds shall be used to expand access, improve benefits, or augment provider reimbursement, or for a combination of those purposes. CalOptima's board adopted a policy for reserve funds that took effect in 1996, and in 2012 the reserve level was set at no less than 1.4 months and not more than 2.0 months of certain CalOptima revenues; this upper range is consistent with the GFOA's recommendation for government reserves.

CalOptima's board established this reserve level to comply with state requirements, maintain CalOptima's health care delivery system during short-term crises, and protect CalOptima's long-term financial viability. The policy allows CalOptima staff to use the reserves to provide payments to providers and vendors in the event of a delay in CalOptima's receipt of revenues from the State. However, this policy does not specify, as the county ordinance requires, what CalOptima will do with any surplus funds it accumulates that are not part of its reserve.

By June 2022, CalOptima had combined reserves and surplus funds equivalent to 3.5 months of revenues, considerably more than the reserves its policy specifies, as Figure 3 shows. These surplus funds represent $740 per member that CalOptima should have used as specified in county ordinance for purposes such as expanding access. CalOptima could have done so, for example, by incentivizing providers to serve additional CalOptima members. The most significant increases in surplus funds have occurred since June 2017, when there was less than $29 million in surplus funds. Between then and June 2022, this surplus increased to $675 million.

Figure 3
Since 2018 CalOptima's Combined Reserves and Surplus Funds at Fiscal Year-End Have Exceeded the Maximum Level Established in Its Policy



Source: CalOptima's audited financial statements for fiscal years 2013–14 through 2021–22, its reserve policy, and interviews with its controller.

Note: According to its controller, CalOptima keeps its reserve funds in specified investment accounts, and it has not transferred additional funds into those accounts since 2017. However, because CalOptima's revenue increases and decreases over time, the number of months of revenue the reserve funds represent will change over time if CalOptima takes no action.

* Although CalOptima had surplus funds sufficient to meet the reserve requirement in fiscal year 2013–14, it had not yet transferred the funds into accounts for that purpose.

CalOptima's reserves and surplus funds increased for several reasons. From June 2014 through June 2017, some of the increase was because of the Medi-Cal expansion program that started on January 1, 2014, in response to the Affordable Care Act. CalOptima's CFO explained that during 2014 and 2015, CalOptima's reserves increased due to expansion members. She stated that DHCS set the rates it paid managed care plans for expansion members using assumptions based on other types of members such as seniors and persons with disabilities, and that after implementing the program, the expansion population turned out to be more comparable to the Medi-Cal adult population. Essentially, DHCS overpaid managed care plans for the cost of caring for the expansion members. The CFO said that the payments for this population resulted in CalOptima's

having a higher-than-usual margin of revenue over expenditures—or profit—for expansion members until DHCS reduced the rates for expansion members beginning in 2015.[2] Beginning in fiscal year 2018–19, a variety of other factors contributed to the increases in CalOptima's surplus funds. Table 2 lists some of the factors identified in CalOptima's audited financial statements that contributed to the increase in its surplus funds from fiscal years 2018–19 through 2021–22. According to the CFO, some of the significant contributing factors were related to the COVID-19 pandemic.

Table 2
Several Factors Contributed to the Increase in CalOptima's Surplus Funds Since 2019

FISCAL YEAR	CONTRIBUTING FACTORS	INCREASE IN SURPLUS FUNDS (IN MILLIONS)
2018–19	Increased revenues from rate increases, IGT transfers, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56); nearly $44 million in investment income; and lower medical expenses.	$157
2019–20	Increased revenues from the addition of a new program—the Whole Child Model—and Hospital Directed Payments, IGT transfers, Proposition 56; and $43 million in investment income.	49
2020–21	Increased revenues because of an enrollment increase of 9.4 percent that, according to CalOptima's CFO, was because of the COVID-19 pandemic and the suspension of the Medi-Cal eligibility redetermination and disenrollment process. In addition, the CFO cited lower health care expenses for the newly enrolled members than for other members of the Medi-Cal population and some delayed or deferred nonurgent services. CalOptima also earned $6 million in investment income.	280
2021–22	Increased revenues from an enrollment increase of 8.6 percent, increased rates for new Medi-Cal programs, and COVID-19 testing and treatment services. However, these additional revenues were partially offset by investment losses of $20 million.	102

Source: CalOptima's audited financial statements for fiscal years 2018–19 through 2021–22 and interviews with its CFO.

The CFO noted that she was not directly familiar with the county ordinance requiring CalOptima to implement a financial plan that provides for the expenditure of surplus funds, and she does not know why CalOptima did not adopt such a policy or include that provision in its board-designated reserve policy. The CFO did agree that such a formal policy would be helpful. However, she also suggested that she believes that CalOptima's board did not interpret the county ordinance as requiring CalOptima to have a policy or comprehensive spending plan for using surplus funds. She explained that, instead of a policy or spending plan, CalOptima staff have brought various items to the board for action to spend portions of surplus funds.

[2] In 2018 DHCS took steps to recoup excess payments that managed care plans received for covering newly eligible expansion members, including $102 million from CalOptima, as we described in our April 2019 report titled *Department of Health Care Services: Although Its Oversight of Managed Care Health Plans Is Generally Sufficient, It Needs to Ensure That Their Administrative Expenses Are Reasonable and Necessary*, Report 2018-115.

The CFO said she believes that when CalOptima does spend surplus funds, it has spent them for the purposes that the county ordinance specifies. However, regardless of whether the surplus funds it has spent were used for the purposes established in the county ordinance, CalOptima has spent only some of those funds and has not established a financial plan for using the remainder to expand access, improve benefits, or augment provider reimbursement, or for a combination of those purposes, as the county ordinance requires.

When CalOptima has identified projects for using surplus funds, it has struggled to spend the funds in a timely manner. For example, CalOptima's strategic plan for 2020 to 2022 describes committing enhanced funding for health initiatives to benefit members experiencing homelessness. However, as of June 2022—more than three years after CalOptima's board authorized it to spend $100 million of its surplus funds for those initiatives—CalOptima had allocated approximately $60 million of that total and spent only $34 million. The CFO explained that CalOptima encountered several challenges that slowed down the implementation of new programs and initiatives, challenges that included multiple competing priorities from DHCS and CMS, higher than usual rates of staff turnover and vacancies, and the COVID-19 pandemic.

Some of the Ways Managed Care Plans Can Use Surplus Funds to Benefit Their Members

- Provide medical services or benefits not normally covered by Medi-Cal, such as community health workers and medically necessary home modifications.
- Pay for medical services when providers are not equipped to bill the responsible party, such as voluntary inpatient detox care that counties are responsible for funding.
- Improve data about members' medical history by obtaining the medical records for care they received outside of the U.S.
- Make supplemental payments to providers for performing the services associated with certain medical procedure codes that are linked to plans' quality scores, such as preventive health screenings.
- Offer members incentives, such as gift cards, if they receive health screenings or vaccinations.*
- Pay providers incentives for keeping later hours or opening on additional days, accepting more Medi-Cal patients, or setting aside specific days and times for seeing Medi-Cal patients.
- Make supplemental payments for certain services only provided by specialists to incentivize those specialists to treat Medi-Cal patients.

Source: The chief of managed care quality and monitoring at DHCS.

* Subject to DHCS approval.

Regardless of whether these challenges fully explain CalOptima's struggle to spend the funds it did allocate for this purpose, there were hundreds of millions of dollars in additional surplus funds for which CalOptima did not even identify a purpose. The chief of managed care quality and monitoring at DHCS detailed a number of other ways that managed care plans such as CalOptima can use surplus funds to benefit their members, some of which we present in the text box. At a minimum, CalOptima could have begun the process of spending the surplus funds by allocating them for some of the ideas that the DHCS chief described to us, such as making supplemental payments to providers for certain medical procedures or providing them with incentives for keeping later hours or accepting more Medi-Cal patients. Devoting funds for these purposes might have addressed CalOptima's rising surplus more promptly and might have improved access and quality of care for its members.

According to CalOptima's chief executive officer (CEO), he cannot speak to why CalOptima accumulated surplus funds and did not use them sooner, but in December 2022 CalOptima's board approved more than $240 million in new allocations.

Allocating these funds for a specific purpose is an important step; nevertheless, allocations alone will not reduce CalOptima's surplus. If CalOptima struggles to spend them, as it has in the past, the surplus may continue to grow. Moreover, according to information the CEO shared with the board in March 2023, CalOptima still had more than $400 million in surplus funds that had not been allocated.

CalOptima's Reserve Policy Was Similar to Those of Other Managed Care Plans

Although CalOptima had accumulated significantly more unspent funds as of June 2022 than its reserve policy allowed, the reserve policy itself appears reasonable. To determine whether CalOptima's reserve policy was reasonable, we compared it to the reserve policies of four other managed care plans, as the text box describes. We found that CalOptima's policy was similar to the other plans' policies and that the purposes of the reserve described in those policies were generally similar. When we spoke with staff at the other plans, the reasons they cited for the level of reserves they established in their policies were generally consistent and included the following considerations:

- The possibility of late Medi-Cal payments.
- Differences between when they receive Medi-Cal payments from the State and when they pay their providers.
- Improving their ability to respond to unexpected costs and cash flow issues associated with changes in coverage and enrollment growth in the Medi-Cal program.
- Other unexpected circumstances.

CalOptima's CFO described similar reasons for the level of reserves defined in CalOptima's policy and said that she reviews the policy annually and recommends changes to CalOptima's board if necessary. As we noted above, although the CFO believes the level of reserves established by the current policy is sufficient, CalOptima has surplus funds that significantly exceed that amount.

Other Managed Care Plans We Reviewed

As part of our review, we compared CalOptima's financial reserves, percent of IGT funds retained, executive management salaries, executive credential requirements, and executive turnover rate to those of the managed care plans listed below. We selected the managed care plans based on their member enrollment, revenues, geographic location, and type. These plans' reserve policies each specify a certain number of months or days for their reserves, unlike the range of months specified in CalOptima's policy.

- Central California Alliance for Health
  Counties served: Merced, Monterey, and Santa Cruz
  Type of plan: Public—county organized health system
  Reserve specified by policy: 3 months*
- Community Health Group
  Counties served: San Diego
  Type of plan: Private—not-for-profit
  Reserve specified by policy: 4 months†
- Inland Empire Health Plan
  Counties served: Riverside and San Bernardino
  Type of plan: Public—established by local initiative
  Reserve specified by policy: 60 days†
- Partnership HealthPlan of California
  Counties served: 14 Northern California counties
  Type of plan: Public—county organized health system
  Reserve specified by policy: 60 days†

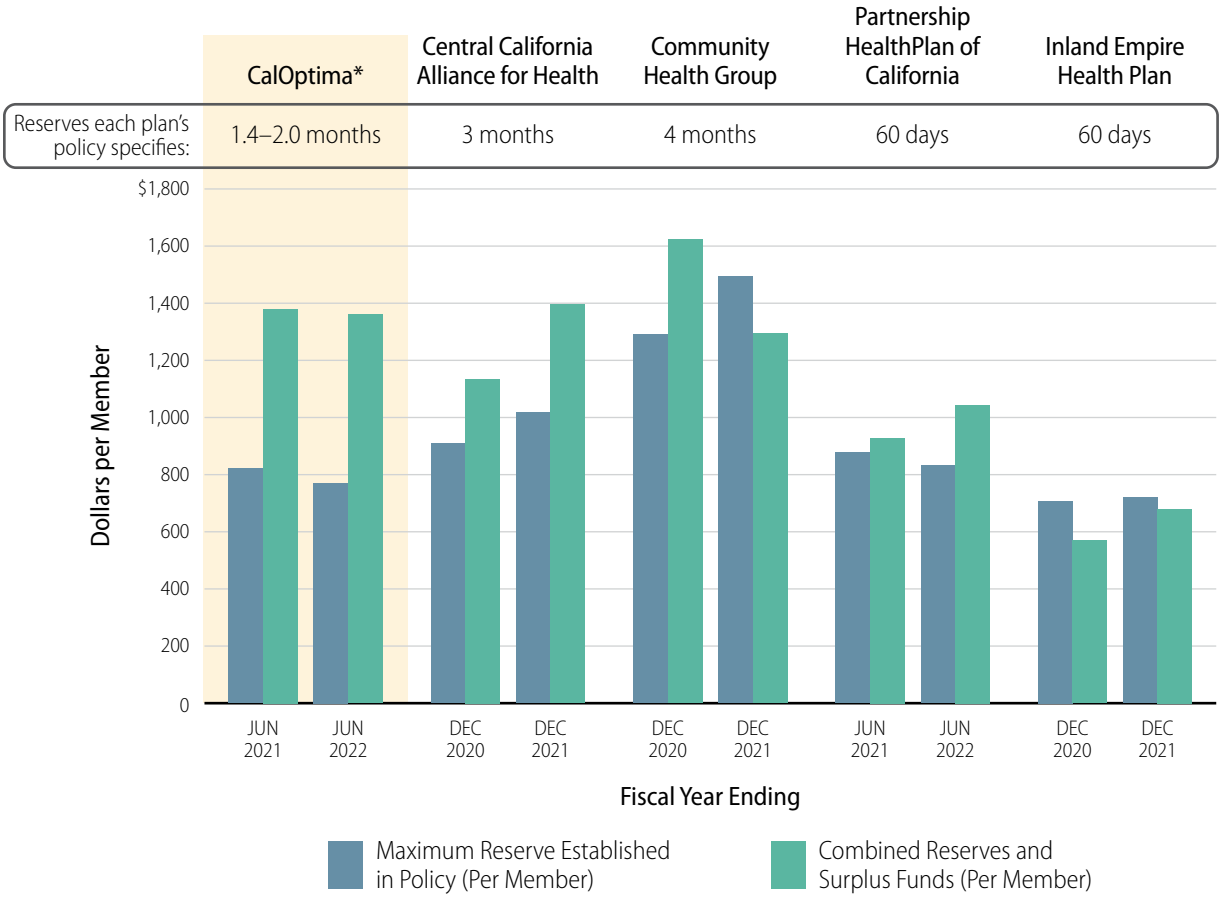
Source: Managed care plans' websites, reserve policies, and interviews with managed care plans' staff.

* Months of reserves based on the amount of certain revenues described as the premium capitation.

† Months of reserves based on monthly operating expenses.

Other managed care plans have maintained amounts of funds that more closely align with their reserve policies. Since 2018 CalOptima's combined reserves and surplus funds have exceeded the range its policy specifies, at times by a considerable amount, as we show in Figure 3. To determine how other plans compare to CalOptima, we compared each plan's combined reserves and surplus funds—on a per-member basis for the plan's two most recently audited fiscal years—to that plan's reserve policy. Because DHCS pays different rates to different managed care plans, two plans with reserve policies requiring the same number of months of reserves are likely to have different reserve amounts per member. Nevertheless, as Figure 4 shows, CalOptima's combined reserves and surplus funds per member exceeded its policy by a greater degree than any of the other plans we reviewed.

Figure 4
CalOptima Exceeded Its Designated Reserves to a Greater Extent Than Other Managed Care Plans Exceeded Theirs



Source: Managed care plans' audited financial statements and reserve policies.

Note: CalOptima and Central California Alliance for Health base their reserves on the amounts of certain revenues, and the three other plans base their reserves on their operating expenses.

* The reserve amount shown for CalOptima is 2.0 months—the maximum amount its policy specifies.

Recommendations

To ensure that it uses its existing surplus funds for the benefit of its members and to comply with county ordinance, by June 2024 CalOptima should create and implement a detailed plan to spend its surplus funds for expanding access, improving benefits, or augmenting provider reimbursement, or for a combination of these purposes. This plan should be reviewed by its board and approved in a public board meeting.

To comply with county ordinance and to ensure that in the future it does not accumulate surplus funds in excess of its reserve policy, by June 2023 CalOptima should adopt a surplus funds policy or amend its policy for board-designated reserves to provide that if surplus funds accrue, CalOptima will use those funds to expand access, improve member benefits, or augment provider reimbursement, or for a combination of these purposes. The policy should require that the board review the amount of surplus funds each year when it receives CalOptima's audited financial statements and direct staff to create an annual spending plan subject to the board's approval to use those funds within the next 12 months.

CalOptima Retained a Larger Share of IGT Funds Than Other Managed Care Plans

Key Points

- CalOptima's excessive surplus funds resulted, in part, from IGT funds that CalOptima retained and did not spend for purposes it had identified, such as providing supplemental payments to its Medi-Cal providers.
- CalOptima historically retained a significantly larger percent of IGT funds than other managed care plans we reviewed, but as of August 2022, it retains only 2 percent of those funds, and it recently reported that its board has allocated substantially all of its remaining IGT funds to various programs.
- CalOptima allocated IGT funds for initiatives addressing the health needs of members experiencing homelessness. However, its efforts to monitor the success of the programs it funded were inconsistent.

CalOptima Retained IGT Funds It Could Have Used to Help Support Health Care Access for Its Members

As the Introduction established, the purpose of the IGT process is to increase payments to managed care plans, enabling them to more fully compensate providers of Medi-Cal services and support the Medi-Cal program. CalOptima's funding partners use IGT funds to pay for a variety of services, such as those the text box lists. From fiscal years 2012–13 through 2021–22, CalOptima received $815 million in IGT funds, of which it distributed $582 million to its funding partners and retained $233 million. The rates at which CalOptima retains these funds are defined in the contracts CalOptima executes with its funding partners. For example, for the round of IGT funding it received during fiscal years 2020–21 and 2021–22, CalOptima and its funding partners agreed that it would retain 31.35 percent of the IGT payments it received from DHCS.

Some Services That CalOptima's Funding Partners Provide to Medi-Cal Members With IGT Funds

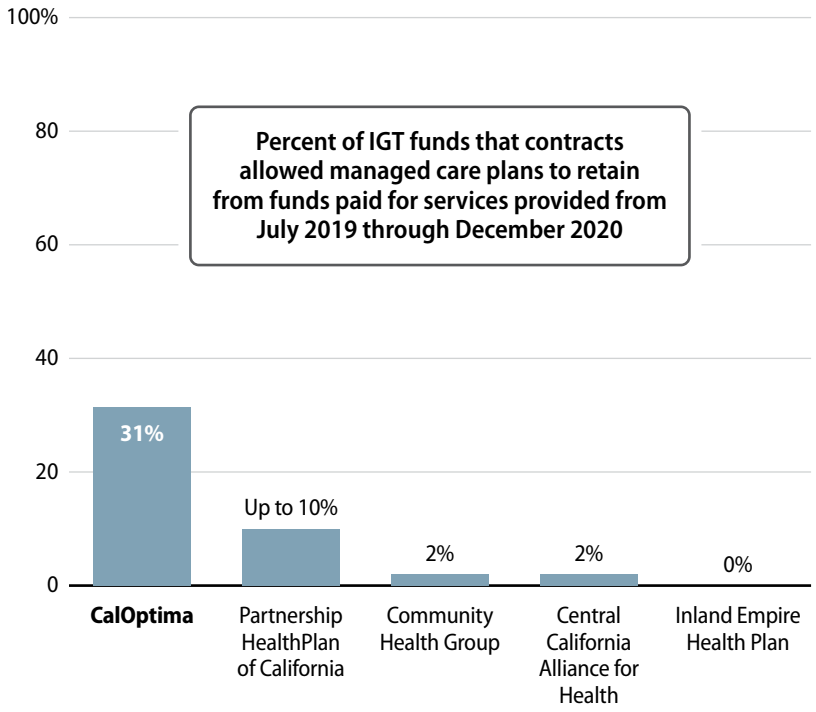
- Testing for sexually transmitted diseases, as well as counseling and prevention services.
- Diagnosis, treatment, and case management for members with tuberculosis.
- Perinatal substance abuse nursing services.
- Health assessment team for members experiencing homelessness.
- Emergency transportation services provided by city fire departments.
- Senior health outreach and prevention program services.
- Inpatient, outpatient, and emergency medical services.

Source: Letters of interest submitted to DHCS by CalOptima and its funding partners.

Until recently, CalOptima retained a substantially higher percentage of IGT funds than the other managed care plans we reviewed. The amount CalOptima retained from IGTs, which it acknowledged was unique among its peers statewide, averaged nearly 30 percent of total IGT funds received from fiscal years 2012–13 through 2021–22. The other plans we reviewed

each retained 10 percent or less during a recent period we reviewed, as Figure 5 shows. In fact, one managed care plan we reviewed did not retain any IGT funds. By retaining a smaller percentage of the IGT funds, the other managed care plans were able to pass on a larger portion of the revenue they received to their funding partners for compensating providers and for supporting the Medi-Cal program, which are the goals of the IGT process.

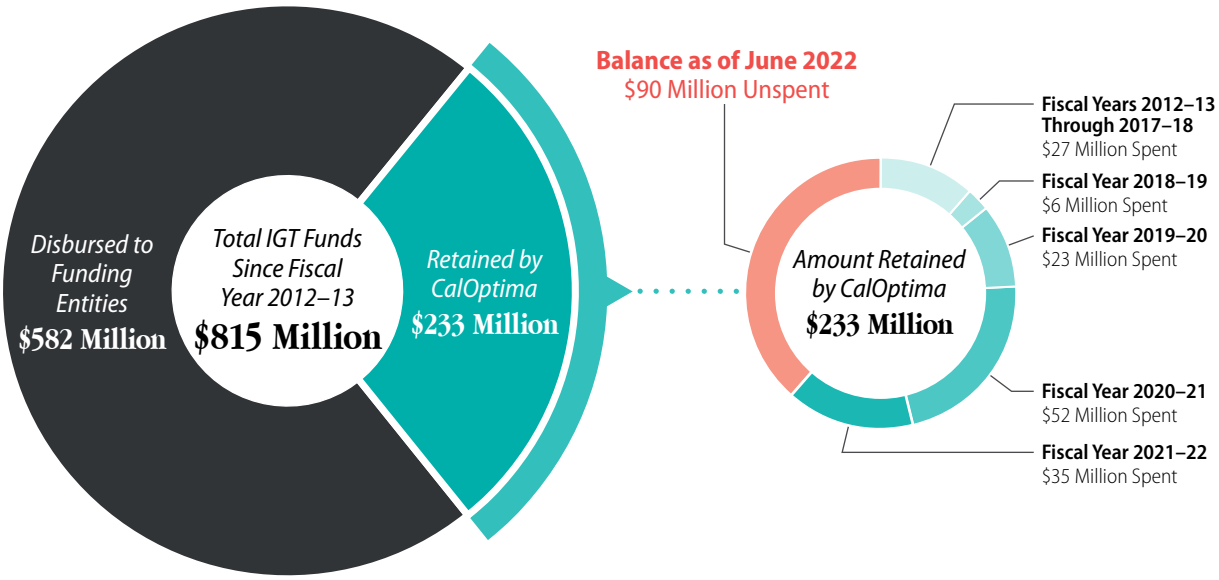
Figure 5
CalOptima's IGT Contracts Allowed It to Retain Significantly More Funds Than Comparable Managed Care Plans' IGT Contracts



Source: Managed care plans' IGT contracts with funding partners and interviews with staff at the managed care plans.

Beginning in August 2022—shortly after this audit began—CalOptima altered its policy to retain only 2 percent of the IGT funds it receives from DHCS excluding the amount the funding partners initially contributed and, with its funding partners, amended the current IGT funding contracts to reflect this change. During the meeting at which the board approved this policy change, the CEO stated that other plans were retaining less and that he thought reducing CalOptima's rate of retention was the right thing to do. Nevertheless, a significant portion of CalOptima's surplus funds were made up of IGT funds it had retained in the past. Although CalOptima has spent more than half of the IGT funds it retained, as of June 2022, it still held $90 million in unused IGT funds, as Figure 6 shows. At that time, these unused IGT funds accounted for 13 percent of CalOptima's surplus funds. This portion of the surplus resulted from CalOptima's retaining IGT funds at a comparatively high rate and from its failure to spend these funds in a timely manner.

Figure 6
CalOptima Had Not Spent $90 Million of the $233 Million in IGT Funds It Retained Since Fiscal Year 2012–13 (as of June 2022)



Source: CalOptima IGT revenue, disbursement, and expenditure data.

Although CalOptima submitted its proposal to retain IGT funds to DHCS, DHCS's oversight of the retention rate is limited. CalOptima's IGT proposals to DHCS have provided very general descriptions of what it intends to do with the retained funds, as demonstrated by the excerpt from the proposal it submitted to DHCS in 2017 shown in the text box. However, under federal regulations DHCS is generally not permitted to direct a managed care plan's expenditures under its contract with the managed care plan to provide Medi-Cal services. According to the CRDD assistant chief, for that reason DHCS has not provided any guidance to CalOptima about the percentage or purpose of the IGT funds CalOptima retains.

Entirety of CalOptima's Explanation to DHCS of How It Intended to Use Retained IGT Funds:

"CalOptima intends to retain approximately 34 percent of the transaction. These additional retained funds will be used to provide Board-approved programs/initiatives which are Medi-Cal covered services that benefit Orange County's Medi-Cal beneficiaries."

Source: CalOptima's IGT funding proposal sent to DHCS in December 2017.

Note: CalOptima used substantially similar language to describe its rationale for retaining similar percentages of IGT funds in five proposals it submitted to DHCS that collectively covered the period of July 2015 through December 2020.

CalOptima initially made statements suggesting that it had retained IGT funds to spend them on the needs of Medi-Cal beneficiaries and individuals without insurance. CalOptima proposed to its board in 2011 that the IGT funds it intended to retain could be used to increase coverage of uninsured individuals, to make supplemental payments to its Medi-Cal providers, or to provide additional financial support to those Medi-Cal providers whose patient load is geared toward serving Medi-Cal beneficiaries or the uninsured. Then, in 2012 when CalOptima proposed to its board that it amend a contract with a consultant who was identifying options

for using its retained IGT funds, it also stated that it was seeking input from various stakeholders and some of its contracted health networks on potential uses of its retained IGT funds.

Notwithstanding the statements it made to its board regarding its intentions to use these funds, the amount of unspent IGT funds that CalOptima retained grew over the next 10 years. The amount of IGT funds CalOptima received from DHCS increased from approximately $40 million in fiscal year 2012–13 to nearly $129 million in fiscal year 2019–20. Because of CalOptima's decision to retain a relatively large percentage of IGT funds it received, the amount retained increased as well. However, in each year from fiscal years 2013–14 through 2021–22, it spent less than half of the prior year's cumulative balance of retained funds.

The reasons CalOptima gave us for not spending these funds more rapidly were not compelling. The CFO stated that in the past three years, CalOptima has increased spending of funds retained from IGTs, but it has encountered challenges that slowed down the implementation of programs to utilize IGT funds. Among the challenges she cited were the COVID-19 pandemic, other competing priorities, changes in the senior leadership team, and challenges securing its board's authority to develop programs and spend the IGT funds. Although we acknowledge that such challenges could affect CalOptima's spending, it maintained a significant and increasing amount of unspent IGT funds for many years. Not only did this fund balance grow for years before the pandemic occurred and during the tenures of various leaders, but CalOptima had approximately a decade to identify that it was not spending the funds it was retaining as fast as it received them and to identify priorities for spending those funds.

Further, CalOptima's accumulation of unspent IGT funds does not align with the requirements it imposes on its funding partners. Most of CalOptima's agreements with its funding partners or their designated providers require them to return overpayments if they do not use IGT funds rapidly. Four of the five contracts it made in September 2020 define overpayments as the amount of IGT payments in a given state fiscal year that exceed the providers' costs of providing services to CalOptima Medi-Cal members in that fiscal year; those contracts require the funding partners to return the overpayments to CalOptima within 60 days. In contrast, at the end of fiscal year 2021–22, CalOptima itself still had unspent IGT funds it had retained from as long ago as fiscal year 2014–15.

CalOptima did take several steps during 2022 to address the balance of IGT funds it had retained. As we discuss previously, CalOptima's board has reduced the amount that CalOptima will retain in the next IGT process to only 2 percent. In addition, in December 2022, CalOptima's board allocated the remaining unallocated funds from the most recent IGT process, and its staff presented reports to the board's finance and audit committee in March 2023, showing that the board had allocated substantially all of its retained IGT funds to various programs. Together, the successful execution of these activities should minimize the balance of CalOptima's unspent IGT funds. Further, if CalOptima were to implement our recommendation that it adopt or amend its policies to require its board to annually review the amount of its surplus funds, the board would be aware of any future accumulation of unspent IGT funds.

CalOptima Was Inconsistent in Monitoring the Effectiveness of Its Homeless Health Initiatives

CalOptima has allocated a significant portion of retained IGT funds for health care initiatives focused on its members experiencing homelessness. In April 2019, CalOptima's board designated $100 million for Homeless Health Initiatives (HHI funds) to address the health of those members. Appendix A provides details on 10 such initiatives. In December 2019, the board approved the general guiding principles for using HHI funds that the text box shows. The fourth guiding principle specifically describes establishing measures of success to increase accountability. However, as we detail below, our review of a selection of Homeless Health Initiatives found that CalOptima did not consistently establish such measures for its initiatives.

CalOptima's Guiding Principles for Homeless Health Initiatives

Transparent and Inclusive—CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.

Compliant and Sustainable—CalOptima shall spend funds on allowable uses only, with the strict rule that certain funds must be used for Medi-Cal-covered services for Medi-Cal members.

Strategic and Integrated—CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.

Defined and Accountable—CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.

Source: CalOptima board meeting materials and minutes.

The requirement to establish measures of success aligns with best practices established by the federal government. For example, the U.S. Government Accountability Office indicates that effective performance management helps improve outcomes in various areas, including health care. It has established a framework for implementing programs and delivering services that includes setting annual and long-term goals and measuring progress toward those goals. Similarly, the framework for effective program evaluation established by the Centers for Disease Control and Prevention (CDC) incorporates indicators and measures to determine whether a program is being implemented as expected and achieving its outcomes. It also notes that outcomes must be precise, documentable, and measurable.

Before it began designating funds for Homeless Health Initiatives, CalOptima established a process for applying for IGT funds (IGT application process). The IGT application process incorporated requirements that aligned with federal guidance and the principles that CalOptima's board subsequently established for the use of HHI funds. For example, the application form that CalOptima used for projects seeking IGT funds in 2016 indicates that applicants should describe how they will know the project was successful, what type of data will be used to measure success, and approximately how long it will take to determine whether the project has been successful. In addition, the review form for these applications prompts CalOptima's reviewers to score the applications on categories that include whether the objectives are effective and measurable. According to CalOptima's executive director for Medi-Cal and CalAIM (executive director), CalOptima did not use the IGT application process for HHI funds. However, because HHI funds come from CalOptima's retained IGT funds and because of the board's guiding principles, we expected to see a similar application process and requirements for HHI funds. Alternately, had CalOptima chosen to use its existing IGT application process, it is likely it would have more consistently identified measures of success and the data necessary to measure progress toward them.

We reviewed seven of the 10 initiatives that CalOptima supported with HHI funds and found that in two instances, CalOptima did have measures of success, and it tracked related data. For example, CalOptima's contract with one participating health center established a requirement for certain clinical field teams to respond to calls from its homeless response team. The contract includes a requirement for the health center to respond to the calls within a specific amount of time, which is a measurable level of performance or metric of success (metric), and CalOptima collected data that it could use to determine whether clinical field teams achieved that metric.

However, in other instances CalOptima did not follow the principle that its board had created of establishing measures of success. Of the seven initiatives that we reviewed, five did not have defined metrics or did not provide data related to the metric, as Table 3 illustrates. For instance, as of June 2022 CalOptima's board had allocated $4 million in HHI funds to its Homeless Clinic Access Program to, among other things, compensate clinics for providing preventive and primary health care services at locations including shelters. Although CalOptima collects data on the number of individuals served through this initiative, the executive director explained that CalOptima did not identify a metric because this was a new initiative, and it was difficult for CalOptima to know what the volume of individuals seen would be. Nonetheless, the data CalOptima provided for this initiative included factors for which it could have established a metric, such as the number of hours offered at locations each month. By not establishing a metric for this initiative, CalOptima is not well positioned to evaluate the effectiveness of this program for improving health care for members experiencing homelessness.

Table 3
CalOptima Was Not Consistent in Its Approach to Monitoring Selected Homeless Health Initiatives

HOMELESS HEALTH INITIATIVE*	DEFINED A METRIC FOR SUCCESS	PROVIDED RELATED DATA
Recuperative Care	X	X†
Clinical Field Teams	✓	✓
Homeless Response Team	X	✓
Homeless Coordination at Hospitals	X	X
Homeless Clinic Access Program	X	✓
Vaccination Intervention and Member Incentive Strategy	✓	✓
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	X	✓

Source: CalOptima's contracts with its Homeless Health Initiative service providers, Homeless Health Initiative outcome data, CalOptima position descriptions, CalOptima desktop procedures, materials presented to CalOptima's board, and interviews with CalOptima staff.

* See Appendix A for information on each initiative's purpose and amount of funds spent as of June 2022.

† We obtained spreadsheets related to this initiative from CalOptima, but according to the executive director, CalOptima did not track data for the initiative. The project manager who provided the spreadsheets explained that they did not show outcomes but were invoices for reimbursement of eligible recuperative care stays. She explained that the spreadsheets allowed CalOptima to only reimburse for stays that were eligible.

CalOptima did even less to establish measures of success and track the data to monitor the impact of other initiatives that we reviewed. For example, CalOptima allocated $2 million in HHI funds annually for five years to its Homeless Coordination at Hospitals initiative, which is intended to help hospitals with the increased costs associated with discharge planning requirements and to help facilitate the coordination of services for homeless individuals with other providers and community partners. As Table 3 shows, CalOptima did not provide data related to this initiative. When we asked for documentation of the outcomes for this initiative, the executive director explained that she was not aware of any outcomes for it. The only outcome for this program that was described to us was provided by the chief operating officer, who said that the outcome was executing contract amendments to include the supplemental funds. Therefore, the only metric that CalOptima established was to distribute funds, and it did not establish an expectation or measure for how those funds would improve the health of its members.

If CalOptima did not expect that there would be improvements to its members' health as a result of the funds spent for this purpose, it is unclear why it chose to allocate funds to this initiative. Further, if there are outcomes that CalOptima does not measure because it is difficult to do so, CDC best practices suggest that programs can be evaluated through the use of indicators relating to any part of the program, including input, process, and outcome indicators. For example, CalOptima might have measured the number of homeless members for whom hospitals developed discharge plans that included referrals to other agencies. Without metrics to measure and monitor, it is not clear whether this initiative—which represents 10 percent of the total HHI funds—has achieved tangible results aimed at improving health care for members experiencing homelessness.

CalOptima described a number of reasons for its inconsistent monitoring of these initiatives. The executive director was not a part of CalOptima when it developed these initiatives, but she shared her understanding of these reasons, which the text box describes. She also said that although CalOptima does not currently have a policy to do so, she believes that to ensure the responsible and equitable use of HHI funds, CalOptima should consistently establish metrics for success of those initiatives and measure progress towards those metrics.

Without a policy, CalOptima's decisions to establish monitoring for individual initiatives that used HHI funds were made inconsistently and appear to have been dependent on external requirements or individual staff decisions. For example, in September 2022 CalOptima's board

Causes of Monitoring Inconsistencies

- CalOptima viewed IGT funds as different from HHI funds, and thus for Homeless Health Initiatives it did not use a process that required the identification of a measure of success and relevant data.
- CalOptima wanted to distribute HHI funds in the fastest and most flexible way possible to ensure the greatest impact in the fastest time frame.
- Some initiatives were difficult to implement, and CalOptima focused on making funds available to serve a broad purpose instead of establishing a metric of success for the use of funds that might have discouraged participation in the initiatives.
- CalOptima does not have a policy governing its approach to monitoring the use of HHI funds.
- Different CalOptima leaders were responsible for the various initiatives and did not take the same approach to monitoring them.

Source: CalOptima's executive director for Medi-Cal and CalAIM.

Housing and Homelessness Incentive Program

A voluntary DHCS incentive program–effective January 2022–intended to support delivery and coordination of health and housing services by doing the following:

- Rewarding managed care plans for developing the necessary capacity and partnerships to connect their members to needed housing services.
- Incentivizing managed care plans to take an active role in reducing and preventing homelessness.

DHCS requires managed care plans that participate in the program to provide information on performance goals and measures, and payment to managed care plans is based, in part, on the achievement of program measures.

Source: DHCS All Plan Letter 22-007.

allocated $40 million of the HHI funds for DHCS's new Housing and Homelessness Incentive Program, which the text box describes. Payments to managed care plans through this program are based, in part, on specific metrics, such as the number of members experiencing homelessness who received at least one of the managed care plan's housing-related services. In January 2023, CalOptima solicited proposals to fund $36.5 million worth of projects in Orange County to mitigate the impact of homelessness, and according to the executive director, in March 2023 the board approved grant agreements for 34 of the 66 proposals received. The executive director also stated that her team is establishing metrics for newer initiatives, such as CalOptima's Street Medicine initiative, which we describe in Appendix A. Nevertheless, a policy formalizing an appropriate and consistent approach to monitoring the use of HHI funds would help CalOptima ensure that the steps its executive director is taking will continue in the event of a change in leadership from executive turnover, the frequency of which we discuss further in the next section.

Recommendation

To ensure that it can determine whether funds allocated to initiatives intended to improve the health of CalOptima members experiencing homelessness are accomplishing their intended purpose, by June 2023 CalOptima should develop a policy that requires it to do the following when spending those funds or allocating funds for that purpose in the future:

- Establish one or more goals for the use of the funds.
- Establish one or more metrics signifying the successful accomplishment of its goals.
- Measure progress toward the established metric and provide the board with periodic updates on the effectiveness of its use of funds based on those measurements.

CalOptima Did Not Follow Best Practices When Hiring for Some Executive Positions

Key Points

- A former CalOptima board member appears to have violated a state law that prohibits public officials from being financially interested in certain contracts when he entered into an employment contract with CalOptima to serve as its CEO in 2020.
- CalOptima has experienced higher executive turnover than the other managed care plans we reviewed, and it lacks a written policy governing its process for hiring employees. Further, it did not follow best practices or the process it verbally described to us when it hired three of the six executives we reviewed.

CalOptima's Board Likely Improperly Hired One of Its Own Members to Serve as the Organization's CEO

A former CalOptima board member appears to have violated state law when he entered into a contract with CalOptima to serve as its interim CEO. Government Code section 1090 generally prohibits state and local officers or employees from being financially interested in any contract made by them in their official capacity or by any boards of which they are members. Courts have found that the purpose of this law is not only to strike at actual impropriety but also the appearance of impropriety. In March 2020, CalOptima's then-CEO (CEO 1) announced his pending resignation effective May 2020, and the board subsequently selected one of its members to serve as the interim CEO (CEO 2) and entered into an employment contract with him. Based on the requirements in law and holdings in court cases related to this issue, CEO 2 had a financial interest in this contract, and it does not appear that any exception to the prohibition contained in Government Code section 1090 is applicable. Therefore, it appears that he was prohibited from entering into the employment contract. Despite this fact, CalOptima's board materials indicate that CalOptima's chief legal counsel at the time concurred with the board's action, and the board materials do not contain a record of his raising a legal objection to the contract.

CalOptima's current legal counsel stated that without a formal investigation, he did not know of any reason why this contract would not be considered a violation of law. However, he also confirmed that CalOptima's legal counsel at that time no longer works for CalOptima, that none of the current members of CalOptima's board were regular members of its board at that time, and that the employee involved (CEO 2) no longer works for CalOptima. Nevertheless, when CalOptima's board chose to hire one of its own members to be the CEO, it created the appearance that the board was acting in the best interest of the individual involved rather than the best interests of the individuals CalOptima serves. Because of our concerns regarding the possible violation of state law, we have referred this matter to the Fair Political Practices Commission.

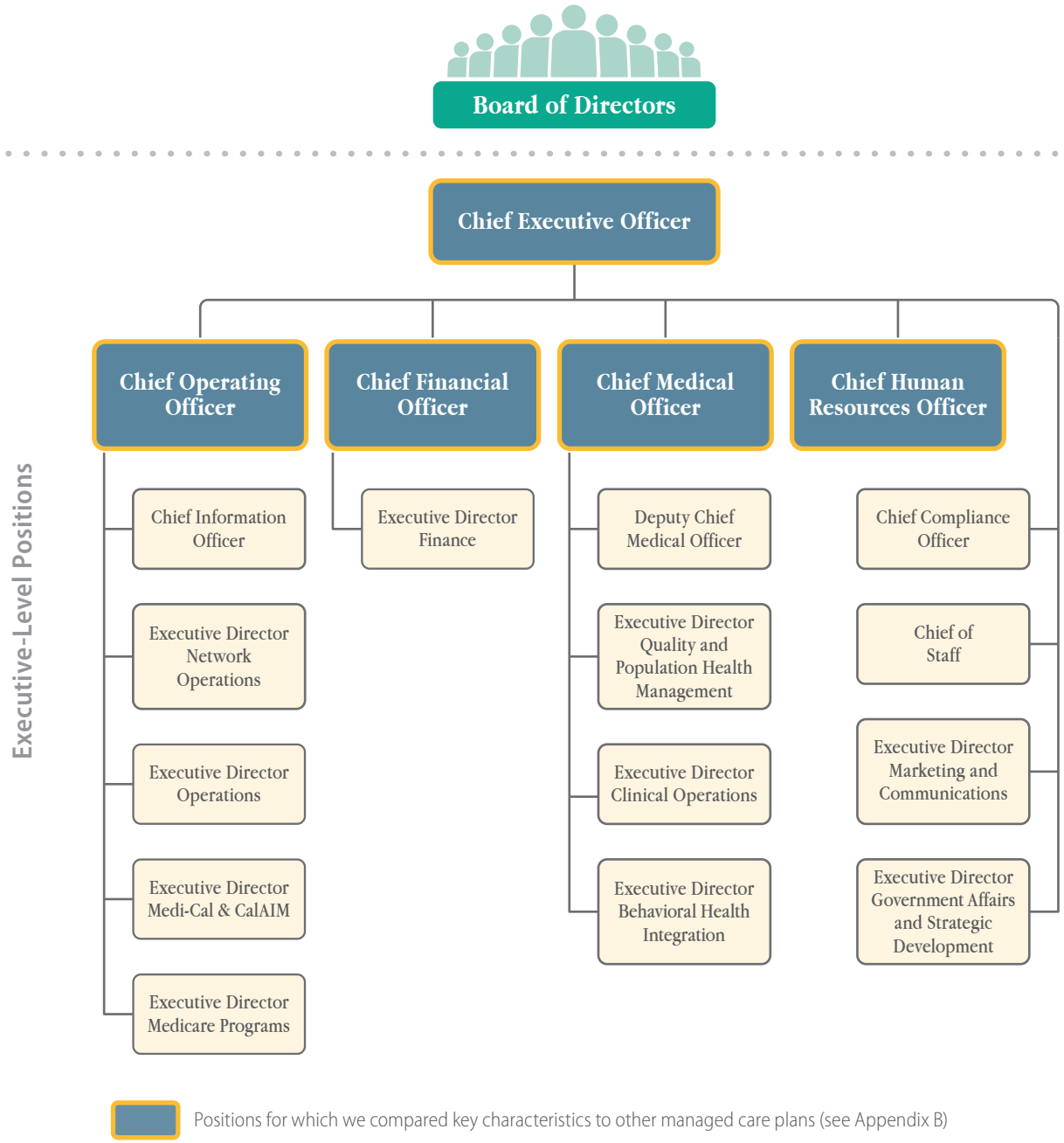
CalOptima's current legal counsel also stated that in August 2022, CalOptima revised its bylaws in a way that—along with amendments to a section of state law—would prevent this situation from occurring again. However, we disagree. The changes to CalOptima's bylaws only apply to certain CalOptima board members and would not have applied to the board member in question. Further, the amendments to state law only clarified that CalOptima's board members were subject to the prohibition in Government Code section 1090—a prohibition they were already subject to before the amendments. When we pointed out these facts and asked whether CalOptima's legal counsel saw any issues with CalOptima amending the bylaws to create a broader prohibition on employing board members, he stated that CalOptima will amend its bylaws.

CalOptima's Approach to Executive Hiring Limited Its Ability to Attract and Select the Most Qualified Candidates

From 2014 through 2022, CalOptima's executive turnover rate averaged 23 percent per year, and it was higher than that in recent years—31 percent in 2020 and 50 percent in 2021. Figure 7 shows CalOptima's executive level positions as of December 2022. For comparison, we reviewed the average annual executive turnover rate for the four managed care plans that we listed in the text box on page 12 and found that their annual executive turnover rates ranged from 6 percent to 15 percent. Given the significant number of new executives CalOptima has hired in recent years, we expected it to have a well-defined hiring policy that aligns with best practices for selecting the most qualified candidates through a fair and rigorous hiring process. However, CalOptima does not have such a policy.

CalOptima states on its website that it makes all employment decisions based on merit. The advantages of a hiring process based on merit principles are accepted at various levels of government. For example, Congress has declared that the quality of public service at all levels of government can be improved by the development of systems of personnel administration consistent with merit principles. Federal law also describes merit principles such as recruiting, selecting, and advancing employees on the basis of their relative ability, knowledge, and skills, including open consideration of qualified applicants for initial appointment. Based on CalOptima's website, we expected that its hiring process would include a number of the characteristics considered to be best practices in merit-based hiring processes, such as advertising positions for a minimum number of days; screening applicants based on their knowledge, skills, and abilities; interviewing candidates using a panel of interviewers; and using the same interview method for each candidate. However, CalOptima has no official policy defining its hiring process.

Figure 7
CalOptima's Executive-Level Positions as of December 2022 Were Part of Our Turnover Rate Analysis



Source: CalOptima's website and organizational chart as of December 2022.

CalOptima's Hiring Process (not established in writing)

- CalOptima utilizes a third-party recruitment advertising firm to distribute job announcements to various websites where they are typically posted for a minimum of five days.
- After receiving applications for the posted position, a representative from the human resources department screens the applications and resumes for minimum qualifications as described in the job announcement. CalOptima's hiring manager then selects preferred candidates, and the human resources department schedules interviews with them.
- An interview selection panel typically interviews the selected applicants, and there may be a follow-up interview with the top-scoring candidates.

Source: CalOptima's HR chief.

According to CalOptima's chief human resources officer (HR chief), CalOptima does not have a written policy that governs its hiring process and to the best of her knowledge has not had one since its inception. She described to us the process that she says CalOptima follows, which we present in the text box. The components of the process the HR chief described generally align with those of the process for merit-based hiring of civil service positions in California state government, but they do not reflect certain best practices. For example, the typical minimum job-posting period of five days is less than the 10 working days that state law generally requires state departments to use when posting jobs. Although CalOptima is not subject to that requirement, posting positions for a minimum of 10 working days could increase the number of qualified candidates who apply for the positions that CalOptima advertises. Similarly, the process that the HR chief described does not define a minimum number of candidates to interview. Establishing a minimum number of candidates to be considered in a hiring process can improve an organization's ability to select the strongest candidate and defend its process. For example, the California Department of General Services—which provides a variety of services to other state agencies—recommends a minimum of three candidates to ensure a competitive and objective process.

Moreover, since 2019 CalOptima has hired certain key executives without following the process it described to us. As Table 4 shows, we found that CalOptima did not consistently follow the steps in the process the HR chief described. CalOptima's lack of a written policy describing its hiring process likely contributed to these discrepancies. For example, the HR chief said that when CEO 2 asked her about appointing an external candidate as chief operating officer without a recruitment, she explained to him that CalOptima's policies were silent on the matter, and she suggested a number of possible courses of action, such as seeking approval from the board or posting the position as an interim assignment. However, according to the HR chief, CEO 2 did not pursue the options she suggested and appointed the chief operating officer directly into a permanent position. The HR chief also pointed out that the hiring of the CEO position is not within the authority of the human resources department, but she agreed that the board could establish standards for hiring CEOs, and that a formal written hiring process would make it more likely that CalOptima—including its board and CEO—would incorporate best practices into its hiring practices for executives.

Table 4
CalOptima Did Not Follow the Hiring Process It Described to Us When It Hired Some Executives

		EXECUTIVE DIRECTOR OF HUMAN RESOURCES	CFO	CEO 2	CHIEF OPERATING OFFICER	CEO 3	CHIEF MEDICAL OFFICER
	Year Hired	2019	2019	2020	2021	2021	2022
Actions That Should Be Performed in the Hiring Process That CalOptima's Human Resources Department Described to Us	Post Job Announcement Online	✓	✓	X	†	X	✓
	Screen Applications for Minimum Qualifications	✓ (601 applicants)	✓ (155 applicants)	X	†	X	✓ (21 applicants)
	Conduct Panel Interview of Applicants	✓ (3 applicants)*	✓ (3 applicants)	X	†	X	✓ (1 applicant)

Source: Job postings, applications, interview notes, screenshots from CalOptima's job-tracking system, internal emails, board agendas and minutes, and interviews with CalOptima staff.

* CalOptima's recruitment manager asserted that CalOptima also interviewed a fourth applicant—the individual it hired. CalOptima provided emails indicating an interview with this individual was scheduled, but the recruitment manager could not locate the interview panel's documentation for that interview as he did for the other candidates.

† According to CalOptima's recruitment manager, an outside recruiter placed the chief operating officer at CalOptima, and CEO 2 appointed the chief operating officer. For this reason, CalOptima does not have the files that it would normally keep as a part of its standard practice. The recruitment manager stated that he did not know how the recruiter was selected, how the recruiter selected the candidate, or whether the recruiter considered any other candidates for the position.

We also identified inconsistencies between CalOptima's publicly stated intentions for hiring executives and its actions. In March 2020, before hiring CEO 2, CalOptima issued a press release announcing a nationwide search for a new CEO. According to a staff report to the board provided in the same month, it was essential to recruit properly qualified candidates in a highly competitive market, and a qualified search firm could help narrow the field and ensure that the board interviewed the most qualified candidates. In May 2020 CalOptima's board authorized a contract with an executive search firm to help it search for a permanent CEO. However, according to CalOptima's human resources manager for recruitment (recruitment manager), the search firm never conducted a nationwide search, and neither CalOptima nor the search firm publicly recruited for the CEO position. The HR chief said the board did not consult with her or the human resources department about its decisions, and she does not know why the board elected not to conduct a nationwide search for a new CEO, even though it contracted with a consultant to do so. In November 2020, CalOptima's board appointed CEO 2—the former board member who was serving as interim CEO—as the permanent CEO.

CalOptima's board engaged in a similar pattern of behavior in 2021. In July 2021, CalOptima engaged a consultant—who had previous experience as the chief executive of hospitals in Southern California—to perform several services, including a review of CalOptima's organizational structure and its hiring processes, and to provide recommendations for improvements. In September 2021, CalOptima announced that CEO 2 would retire in November 2021, and in November, CalOptima's board appointed the consultant as the new interim CEO (CEO 3). According to the chair of CalOptima's board, CEO 3 would serve while the board conducted a national search for a permanent CEO. However, CalOptima did not conduct such a search through its human resources department. The HR chief said that the board did not consult with her or the human resources department about this decision either,

and she does not know why the board elected to choose its new CEO without conducting a nationwide search after the board's chair had stated in a press release that CalOptima intended to do so. In March 2022, CalOptima's board appointed CEO 3 as the permanent CEO.

By twice failing to publicly recruit for a new CEO or consider multiple candidates, CalOptima's board limited its ability to select the most qualified candidates, and it deprived other qualified candidates of the opportunity to apply for the position. Consequently, CalOptima's board opened itself to criticism about the objectivity, appropriateness, and transparency of its hiring process, regardless of whether the individuals CalOptima hired to be its CEO were well qualified for that position.

Recommendations

To ensure that members of CalOptima's board do not violate state law by entering into employment contracts made by the board on which they serve, by June 2023 CalOptima should amend its bylaws to prohibit all CalOptima board members from being employed by CalOptima for a period of one year after their term on the board ends.

To better protect itself from criticism about the objectivity, appropriateness, and transparency of its hiring practices and to help ensure that CalOptima attracts and selects the most qualified candidates, by June 2023 CalOptima's board should adopt a policy that governs its hiring processes for all positions, including executive positions. Such a policy should incorporate best practices, including the minimum length of time that CalOptima will advertise job openings, the minimum number of qualified candidates CalOptima will interview for each position, and a requirement that it will use the same interview method for each candidate for a position. These steps should be documented for each recruitment.

Other Areas We Reviewed

To address the audit objectives approved by the Joint Legislative Audit Committee (Audit Committee), we also reviewed CalOptima processes that pertain to reporting misconduct and preventing retaliation, ensuring timely access to care for its members, and making key financial information transparent for the public.

Efforts to Investigate Reports of Misconduct and Ensure an Atmosphere Free From Fear of Retaliation

We determined that the policies that CalOptima has created for reporting misconduct and prohibiting retaliation against those who make such reports (whistleblowers) generally aligned with applicable laws and recommended practices. The text box shows some examples of recommended practices we identified. We reviewed a selection of reported cases of misconduct—such as fraud, waste, abuse, or noncompliance with laws, regulations, or CalOptima's code of conduct and policies—to determine whether the reporting channels CalOptima has established were being used, CalOptima was following its policies, and whether CalOptima addressed the misconduct it substantiated.

Recommended Practices for Whistleblower Anti-Retaliation Programs

- Implement a strong code of conduct that identifies retaliation as a form of misconduct.
- Create multiple channels for reporting compliance concerns.
- Protect the confidentiality or anonymity of employees who report concerns.
- Provide for fair and transparent evaluation of concerns raised.
- Provide anti-retaliation training.

Source: Recommendations from the U.S. Department of Labor's Occupational Safety and Health Administration and Whistleblower Protection Advisory Committee.

CalOptima's Fraud, Waste, and Abuse unit (FWA unit) has established written procedures that provide instruction and general timelines for the investigation of allegations, but it asserted that those procedures did not apply to nine of the 10 cases we reviewed. According to the director of fraud, waste, abuse, and privacy (director), when the FWA unit reviews an allegation but there is not enough information to conduct a formal investigation, it defines its response as a *monitoring activity*. When the FWA unit reviews an allegation and there is sufficient information, it conducts an *investigation*. From November 2021 through September 2022, the FWA unit described its response to nearly 78 percent of all allegations it received as monitoring activities. Despite this fact, according to the director, CalOptima's procedures do not define the terms "monitoring activity" or "investigation" or specify the types of cases that should be monitored versus those that should be investigated.

We randomly selected 10 cases of alleged fraud, waste, and abuse from the 218 allegations that the FWA unit received from November 2021 through September 2022 and found that nine were addressed through monitoring activities, and one was addressed through an investigation. We attempted to determine whether CalOptima followed selected procedures it has established for such cases and found that CalOptima did follow the written procedures we tested for the investigation. However, we were unable to adequately test the cases that CalOptima addressed through monitoring activities because, according to the director,

CalOptima does not have procedures specific to these activities. The director provided us with conflicting information about which procedures apply to monitoring activities and said that CalOptima's approach has been to decide monitoring activity procedures case by case.

CalOptima's lack of procedures for addressing these cases increases the risk that it will not handle all cases appropriately, and one of the cases we reviewed illustrates how such a failure can occur. In February 2022, DHCS forwarded a complaint it had received to CalOptima and directed CalOptima to investigate and report the findings of its investigation to DHCS. According to the complaint, an individual suspected fraud because they received correspondence from a medical provider they had not seen regarding procedures that were not performed. In addition to DHCS's specific direction to report the findings of its investigation, CalOptima had a contractual obligation to report certain cases of fraud and abuse to DHCS. However, CalOptima defined its response to this allegation as a monitoring activity and determined that the allegation had no relation to CalOptima. CalOptima did not report the findings of its review to DHCS. According to the director, this was because staff have a large workload of cases to review, the analyst likely forgot, and this was simply an oversight. Had the FWA unit investigated this case according to its established procedures, those procedures would have directed the FWA unit to report the results to DHCS. However, without written procedures defining which allegations should be addressed through monitoring activities and which should be addressed through investigations, and without defining the steps staff should take to handle monitoring activities, there is a risk that CalOptima may not be appropriately evaluating other allegations and reporting them to DHCS as it should.

We also reviewed a selection of cases of reported noncompliance and found that CalOptima generally followed its procedures for handling those cases. We randomly selected 10 cases of suspected noncompliance from 143 allegations that CalOptima's regulatory affairs and compliance unit (compliance unit) received in October 2019 and through September 2022. We reviewed whether the compliance unit met certain time frames it had established for handling those cases and resolved them according to its established procedures. We determined that the compliance unit generally did so. We reviewed one case that was submitted in a manner that, according to CalOptima's director of regulatory affairs and compliance for Medicare (compliance director), requires CalOptima to determine what procedures are applicable. Because this case was submitted by an external entity, the way CalOptima communicated with that entity did not fully align with the compliance unit's existing procedures for communicating with internal entities. We brought that discrepancy to the attention of the compliance director. She said that she and others, including CalOptima's chief compliance officer, would discuss the procedures that are appropriate for this type of submission and anticipated revising the unit's procedures as a result.

For CalOptima to effectively address misconduct, potential whistleblowers must feel comfortable reporting it. However, even well-conceived, well-intentioned anti-retaliation programs can founder in implementation, and we saw indications that CalOptima's efforts have not been sufficient to establish an atmosphere free from fear of retaliation. Specifically, some staff members expressed concerns to us about retaliation. According to the chief compliance officer, there have been no reports of retaliation at CalOptima during his tenure, but he acknowledged that it is difficult to know for sure whether retaliation could be occurring. One recommended practice to ensure the effectiveness of anti-retaliation programs is to obtain independently administered, anonymous employee surveys to check behavior and perception. Information from such surveys could help CalOptima determine

the success of its efforts and, if necessary, take steps to improve them. The chief compliance officer stated that CalOptima has not conducted any surveys to determine whether staff know how to report retaliation or other concerns and feel comfortable doing so, but he said that CalOptima could take such action. He also stated that CalOptima's annual compliance and fraud, waste, and abuse training includes information on nonretaliation. We identified an opportunity for CalOptima to improve its compliance training policy by amending the policy to require that training for managers address the disciplinary consequences for retaliating against individuals who report concerns. We communicated this potential improvement to the chief compliance officer in writing, separately from this report.

Recommendations

To reduce the risk that it does not appropriately evaluate allegations of fraud, waste, and abuse and report them to DHCS, by June 2023 the FWA unit should revise its written procedures to clearly specify the types of cases that should be addressed through investigations and the types that should be addressed through monitoring activities. In addition, it should establish written procedures for conducting monitoring activities.

To help ensure the maintenance of an atmosphere free from fear of retaliation for reporting misconduct, by October 2023 and annually thereafter, CalOptima should conduct or contract for an anonymous survey of staff and contractors to determine whether they understand how to make such reports and feel comfortable doing so.

Actions to Improve Timely Access to Care for CalOptima Members

CalOptima has some deficiencies related to timely access to care for its members, including its members experiencing homelessness. CalOptima expects providers to care for its members within legally required timely access standards at least 80 percent of the time. To evaluate providers' compliance with the timely access standards, CalOptima and DHCS contract with third parties to conduct surveys. According to CalOptima's director of quality improvement, CalOptima's survey does not break out performance by member population. The chief of DHCS's managed care quality and monitoring division similarly stated that timely access measures are not tracked by individual member. Thus, we could not use their survey information to determine whether individuals experiencing homelessness receive more or less timely care.

The survey conducted for CalOptima between September 2021 and July 2022 indicates that with one exception, CalOptima's primary care and specialty providers did not meet CalOptima's standard for timely access to routine or urgent appointments. Earlier surveys that CalOptima contracted for during portions of fiscal years 2019–20 and 2020–21 also showed that many primary care and specialty providers were not meeting the standard for timely access to routine and urgent appointments, and DHCS's 2021 Medicaid Managed Care Survey summary report identified that CalOptima performed below the national average for getting care quickly to both adult and child patients. In addition, DHCS issued an audit of CalOptima in 2020 that found, among other things, that CalOptima did not communicate to providers the timeliness standards for members to obtain various types of appointments and did not enforce providers' compliance with those standards.

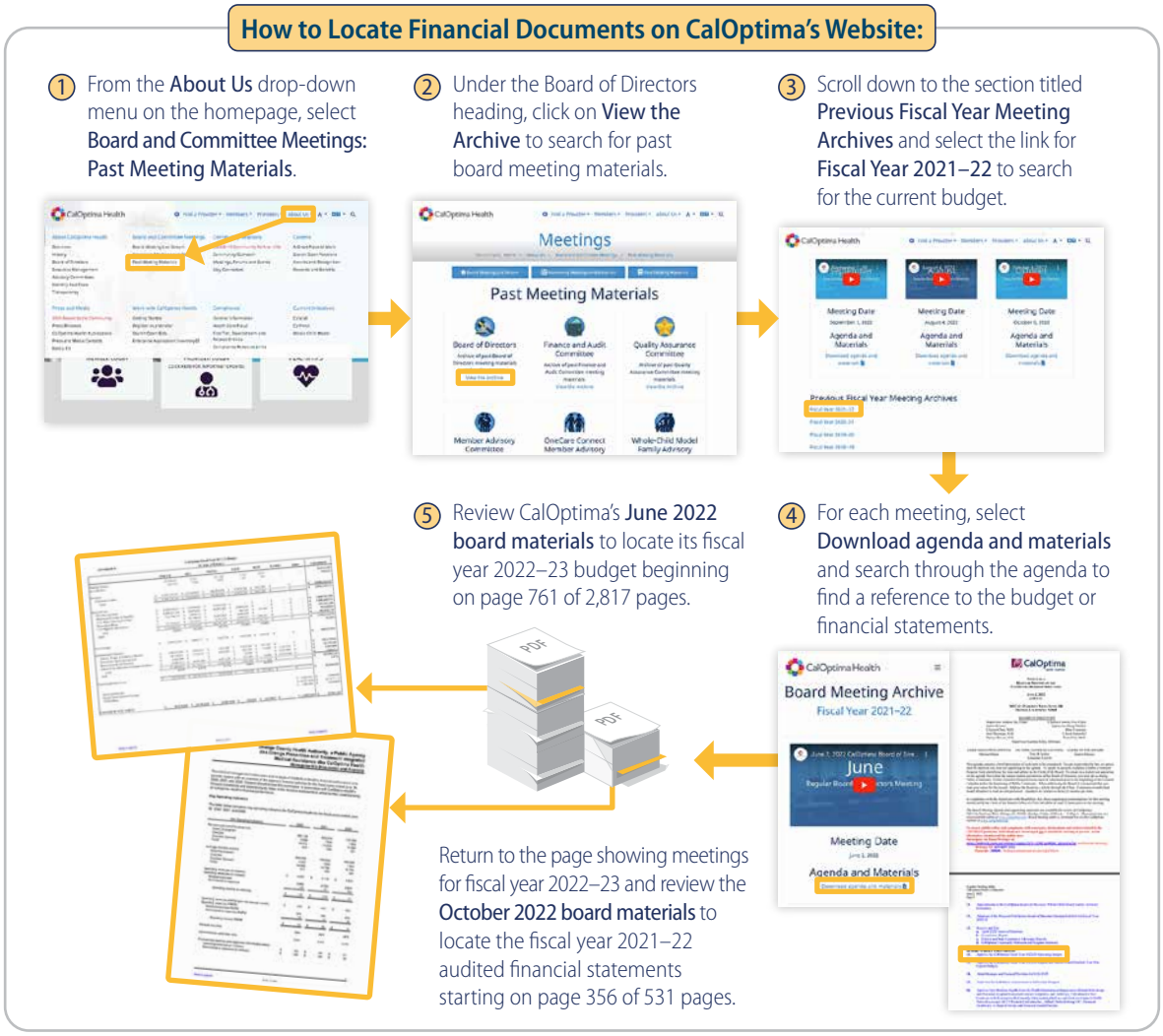
CalOptima has taken action to address these deficiencies. Specifically, to address DHCS's audit finding, CalOptima stated that it intended to implement a number of actions, including monitoring providers' performance and sending education, warning, and escalation letters to individual providers who continue to violate the minimum performance standard for timely access. The letter that CalOptima sends to providers with three consecutive years of noncompliance requires providers to submit a corrective action plan that details the steps they have taken to resolve the cause of the deficiency and the safeguards they have implemented to ensure that the deficiency does not reoccur. According to CalOptima's director of quality improvement, when CalOptima issues a warning letter to a provider, it also assigns an intermediary that trains the provider, determines the root causes for noncompliance, and determines how CalOptima may support the provider in becoming compliant again. In its response to DHCS's audit, CalOptima provided DHCS with certain information about this process, and DHCS notified CalOptima in 2021 that it had accepted CalOptima's plan.

Accessibility of Financial Information on CalOptima's Website

During our audit, we observed that CalOptima's financial documents were difficult to find on its website, limiting CalOptima's transparency and accountability to the public and its stakeholders. CalOptima acknowledges on its website that, as a public agency, it is accountable for managing public resources wisely. However, if members of the public struggle to find its standard financial documents, they may not be able to determine how it is managing its resources. According to the GFOA, motivations for financial transparency may include desires to improve public service and accountability and educate the public about what government does and how it arrives at the decisions it makes. The GFOA also says that online financial transparency can improve overall confidence and trust in government. Specifically, the GFOA encourages every government to use its website as a primary means of communicating financial information to citizens and other interested parties. For example, the GFOA recommends that a link to financial documentation should appear prominently on the homepage or there should be some other tool for users to easily locate the document, such as an internal search tool. Before our audit, CalOptima did not make any of its financial documents available in this way, which may have limited the ability to find these documents and, therefore, diminished the public's overall confidence and trust in CalOptima.

For example, CalOptima's annual budget and audited financial statements were difficult to find on its website. Neither CalOptima's homepage nor the main page of its finance and audit committee, which highlights that it is transparent and accountable, included links to CalOptima's budgets and audited financial statements. Similarly, our queries for the terms *budget* and *audited financial statement* using CalOptima's website search tool did not identify these financial documents. CalOptima includes the documents on its website, but they are a part of the documents it produces for board meetings, some of which are more than 2,000 pages long. As Figure 8 shows, finding these meeting materials took us several steps. In contrast, we identified that another managed care plan—CenCal Health, which serves Santa Barbara and San Luis Obispo counties—makes its audited financial statements for the most recent fiscal year and its current budget readily available through a link from its homepage.

Figure 8
CalOptima's Budgets and Financial Statements Were Difficult to Find on Its Website



Source: CalOptima and CenCal Health websites.

According to the CFO, through the years, CalOptima has tried to provide meaningful financial information to the public in ways that are easily understandable. She explained that CalOptima tries to tailor the financial information it publishes to different stakeholders' needs and levels of understanding. For example, she said that CalOptima posts a "Fast Facts" report that it updates monthly to provide an overview of CalOptima's financials for the general public audience. Although this report is easier to find on CalOptima's website than its financial statements, it does not provide the level of detail contained in CalOptima's budget or financial statements and does not tell its readers how to locate these documents for more detailed information. The CFO said that CalOptima is open to improving accessibility to these more detailed, publicly available financial documents so that members of the public who would like this level of detail may find the information with greater ease. Publishing its annual budget and audited financial statements as individual documents, and providing links to those documents on its website—rather than requiring the public to search through archived meeting materials to find them—would simplify this process. In March 2023, CalOptima informed us it had updated its website and directed us to a webpage that included direct links to its fiscal year 2021–22 audited financial statements, its fiscal year 2022–23 operating and capital budget, and a January 2023 monthly financial summary.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code section 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

GRANT PARKS
California State Auditor

May 2, 2023

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Appendix A

CalOptima's Homeless Health Initiatives

In an effort to be responsive to the needs of members experiencing homelessness, CalOptima's board approved a $100 million Homeless Health reserve in April 2019, which CalOptima could use to fund existing and new initiatives involving medically necessary Medi-Cal services for homeless CalOptima members. As part of this audit, we identified CalOptima's Homeless Health Initiatives as of June 2022. Table A1 shows these initiatives and summarizes the purpose of each, and Table A2 presents financial information for each as of June 2022. Our review of CalOptima's website found that detailed financial information on Homeless Health Initiatives was publicly available but difficult to find. For example, we found information on the amount of funds budgeted and spent for those Homeless Health Initiatives that had been allocated funds as of February 2022. However, this information was located within a request for approval of actions related to Homeless Health Initiatives on page 1,465 of CalOptima's 1,515-page archive of board materials for May 5, 2022.

Table A1
CalOptima's Homeless Health Initiatives as of June 2022

INITIATIVE	PURPOSE
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	Redirect a meaningful percentage of mental health patients from hospital emergency departments to a more appropriate care setting at a regional wellness hub for mental health and substance abuse services. Provide peer support services including linking members to behavioral health services, mental health education, and informal counseling. Eliminate unnecessary paramedic trips and time spent in emergency departments, improve public safety, and improve member outcomes and mortality rates. This facility was not designed exclusively to serve the homeless population but is intended to complement the homeless system of care.
Recuperative Care	Provide post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care, and are appropriate for discharge to home.
Day Habilitation (Support for the County's HomeKey Program)	Provide enhanced services for Medi-Cal members residing in HomeKey sites. These services include, in part, training on the use of public transportation, personal skills development in conflict resolution, and daily living skills. The State's HomeKey Program provides funding to local public entities, including counties, to purchase, rehabilitate, and convert buildings, such as vacant apartment buildings, into interim or permanent housing for qualifying individuals or families who are impacted by the COVID-19 pandemic.
Clinical Field Teams	Provide on-call clinical staff from participating community health centers that travel throughout the community to where individuals experiencing homelessness are located to provide urgent care services such as wound care, prescriptions, and immediate dispensing of commonly used medications.
Homeless Response Team	Provide health care navigation services to members experiencing homelessness and dispatch contracted clinical field team clinics to provide urgent care on-call services. Liaise between the homeless population and CalOptima and its partners, process member requests to change their primary care provider or health network, and arrange transportation for appointments.

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INITIATIVE	PURPOSE
Homeless Coordination at Hospitals	Provide additional funding to hospitals for costs associated with SB 1152 discharge planning requirements, and for hospitals to utilize data-sharing technology to help facilitate coordination of services for homeless individuals with other providers and community partners.
Homeless Clinic Access Program	Provide members experiencing homelessness with access to preventive and primary health services at shelters or other hot spots on a regular schedule.
Vaccination Intervention and Member Incentive Strategy	Provide gift cards as an incentive for CalOptima's members experiencing homelessness to receive their first and second COVID-19 vaccine doses.
Street Medicine	Link individuals to a medical home to reduce unnecessary emergency room use, while also preventing progression of untreated health conditions that result in a high mortality rate among those experiencing homelessness.
Outreach and Engagement	Expand the capacity of an outreach and engagement team, including expanding the hours of availability of field-based access and providing services such as treatment referrals and facilitating the Medi-Cal enrollment of eligible nonmembers.

Source: Materials provided to CalOptima's board, CalOptima contracts with Orange County and the Orange County Health Care Agency, a CalOptima request for qualifications, interviews with CalOptima staff, and a description of the initiatives provided by CalOptima.

Table A2
The Status of Funds CalOptima Allocated for Homeless Health Initiatives as of June 2022

INITIATIVE	ALLOCATED	SPENT	REMAINING
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11,400,000	$11,400,000	$0
Recuperative Care	8,500,000	6,444,000	2,056,000
Day Habilitation (Support for the County's HomeKey Program)	2,500,000	2,500,000	0
Clinical Field Teams	1,600,000	1,600,000	0
Homeless Response Team	6,000,000	1,442,000	4,558,000
Homeless Coordination at Hospitals	10,000,000	7,513,000	2,487,000
Homeless Clinic Access Program	3,963,000	2,905,000	1,058,000
Vaccination Intervention and Member Incentive Strategy	400,000	55,000	345,000
Street Medicine	8,000,000	0	8,000,000
Outreach and Engagement	7,000,000	0	7,000,000
Funds Reallocated to a DHCS Program*	40,100,000	0	40,100,000
Subtotals	**$99,463,000**	**$33,859,000**	**$65,604,000**
Total Funds Unallocated	**$537,000**		
Total Funds Designated for Homeless Health Initiatives	**$100,000,000**		

Source: Board agendas and minutes, summary data on HHI funds as of June 30, 2022, and interviews with CalOptima's executive director for Medi-Cal and CalAIM.

Note: Amounts in this table are rounded to the nearest thousand.

* In September 2022, this portion of funds was reallocated from CalOptima's Homeless Health Initiatives to the DHCS program we describe in the text box on page 22.

Appendix B

Salary Range and Experience Requirements for Selected Managed Care Plans

Although CalOptima did not update its salary schedule for several years, according to CalOptima's compensation administration guidelines, either annually or biennially the organization's pay range targets should be compared to external market base pay practices and adjusted if necessary. In 2014 CalOptima's board approved a new salary structure and salary schedule, and in December 2015 CalOptima increased its pay ranges by 4 percent to keep current with market rates. However, during the next several years, CalOptima made no further changes to its salaries. In 2018 CalOptima hired a consultant to perform a study of CalOptima's total compensation and compensation-related practices. According to the consultant, it was engaged to perform a study of CalOptima's salaries and benefits as compared to other local, regional, and national organizations of similar size and operations such as hospitals, health networks, and other public and private health plans.

According to CalOptima board materials, its consultant completed its review in 2019, finding that CalOptima's total compensation was below the market median at all levels within the organization—from 7 percent below market median for staff positions to 30 percent below for executives—as compared to government, not-for-profit, and for-profit geographic peer groups. However, CalOptima's board did not act on the consultant's recommendations until March 2021, when it approved salary increases. In order to attract more qualified individuals to fill executive positions, in September 2021 CalOptima again increased the salary pay grades for its executive level job titles and its medical directors. According to CalOptima, multiple candidates had declined job offers for medical director positions or withdrawn from the selection process because of the positions' low salaries. In March 2022, CalOptima increased its pay grade maximums for all positions by 10 percent and authorized 6 percent cost-of-living adjustments for all employees, and in June 2022 it increased the minimum salaries for some positions.

To evaluate CalOptima's executive salaries and job requirements, we compared the base salary ranges and education and experience requirements for five executive positions at CalOptima and at the four comparable managed care plans that we list in the text box on page 12. Two of these plans—Central California Alliance for Health and Partnership HealthPlan of California—are county organized health systems like CalOptima and are the sole Medi-Cal managed care plans in the counties they serve. Inland Empire Health Plan is a local initiative organized managed care plan and provides services as the county-sponsored managed care plan in two counties where DHCS also contracts with a commercial managed care plan. Community Health Group is a not-for-profit private managed care plan and one of several managed care plans that DHCS contracts with to serve San Diego County. Although they are not county organized health systems like CalOptima, we included Inland Empire Health Plan and Community Health Group for comparison with CalOptima because of their geographic proximity to Orange County and the number of Medi-Cal members they serve. On average, as of 2022 CalOptima's base salary ranges were higher, and its experience requirements were lower, than those of the four comparable managed care plans for the executive positions we reviewed. We list these salary ranges and education and experience requirements in Table B.

Table B
Managed Care Plans' Salary Ranges and Experience Requirements (December 2022)

		CALOPTIMA	CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	COMMUNITY HEALTH GROUP	INLAND EMPIRE HEALTH PLAN	PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Chief Executive Officer	Current Base Salary*	$841,500				
	Base Salary Range*	$560,000–841,500	$422,960–676,749	$611,644–917,466	$438,609–767,561	$487,854–829,352
	Level of Education	Bachelor's	Master's	Master's	Master's	Master's
	Years of Experience	8	10	15	15	8
Chief Operating Officer	Current Base Salary*	$535,515				
	Base Salary Range*	$433,000–713,900	$279,154–446,659	$295,529–458,070	$324,896–568,568	$390,283–663,481
	Level of Education	Bachelor's	Bachelor's	Master's	Bachelor's	Master's
	Years of Experience	8	12	7	8	7
Chief Financial Officer	Current Base Salary*	$538,380				
	Base Salary Range*	$368,000–607,200	$266,465–426,358	$274,911–426,112	$324,896–568,568	$312,226–530,786
	Level of Education	Bachelor's	Bachelor's	Master's	Master's	Bachelor's
	Years of Experience	8	12	10	10	10
Chief Medical Officer	Current Base Salary*	$595,997				
	Base Salary Range*	$368,000–607,200	$308,761–494,021	$353,157–547,394	$324,896–568,568	$390,283–663,481
	Level of Education	Medical Doctor	Medical Doctor	Medical Doctor	Medical Doctor	Medical Doctor
	Years of Experience	8	12	6	5	7
Chief Human Resources Officer†	Current Base Salary*	$506,395				
	Base Salary Range*	$313,000–515,900	$255,033–408,054	$243,834–365,751	$324,896–568,568	$199,823–339,704
	Level of Education	Bachelor's	Bachelor's	Master's	Master's	Bachelor's
	Years of Experience	8	12	20	15	10

Source: Job descriptions and salary schedules from CalOptima and selected managed care plans.

* Base salaries and salary ranges do not include other payments, such as incentive compensation or car allowances, that could increase total compensation for individuals holding the positions shown.

† Because some plans do not have a dedicated chief human resources officer, we compared CalOptima's HR chief position to the closest comparable position, which for some plans includes other responsibilities in addition to HR responsibilities. At Central California Alliance for Health, the chief administrative officer has HR, communications, and building and facilities management responsibilities. At Community Health Group, the associate chief executive officer assists the chief executive officer with the management of the HR department, as well as working with all other departments. At Partnership HealthPlan of California, a senior director, not a chief, has executive HR responsibilities.

Appendix C

Scope and Methodology

The Audit Committee directed the California State Auditor to conduct an audit of CalOptima to provide information related to its budget, delivery of services and programs, and organizational changes. Table C lists the objectives that the Audit Committee approved and the methods we used to address them.

Table C
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed the laws, rules, and regulations related to CalOptima and the programs it operates.
2	Examine CalOptima's budget, including the amount of revenue CalOptima receives from federal, state, and private sources, and determine whether CalOptima makes its budget and financial information available to the public.	• Analyzed CalOptima's audited financial statements for fiscal years 2019–20 through 2021–22, CalOptima's budget for fiscal year 2022–23, and data we obtained from CalOptima's controller, to identify the amount of revenue it received from federal and state agencies and private sources. • Obtained data from DHCS to identify the portions of CalOptima's revenue that DHCS paid from federal and state funds for fiscal years 2019–20 through 2021–22. • Compared the locations of CalOptima's most recent budget and financial statements on its website to best practices for making information transparent.
3	Evaluate CalOptima's reserve balances since the Affordable Care Act went into effect in 2014 and determine whether the balances comply with applicable requirements and how they compare to other public Medi-Cal managed care plans.	• Determined CalOptima's annual balances of reserves and surplus funds from fiscal years 2013–14 through 2021–22. • Determined whether CalOptima's balances met or exceeded legal requirements and the reserve levels designated by its board from fiscal years 2013–14 through 2021–22 based on data obtained from its audited financial statements. • Interviewed staff and reviewed relevant documentation to determine why balances exceeded the required reserve thresholds, and assessed whether the reserve levels are reasonable. • Identified, requested, and reviewed the financial statements of four other managed care plans and determined their annual reserve balances for their two most recently audited fiscal years. • Determined that CalOptima and the other managed care plans selected for comparison established reserves for similar purposes.
4	Determine how CalOptima collects and spends IGT funding and how much of this funding it retains. Compare the amounts CalOptima collects in this manner to those of other public Medi-Cal managed care plans.	• Analyzed CalOptima's finance department records to determine the amount of IGT funds that CalOptima received, spent, and retained from its implementation of the IGT process from fiscal years 2010–11 through 2021–22. • Reviewed DHCS information on the amount of IGT funds that four comparable managed care plans received for rate years 2019–20 and 2020–21. • Compared the share of IGT funds CalOptima agreed to retain with the retention rate in the IGT agreements of the four selected managed care plans for rate years 2019–20 and 2020–21.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
5	Identify the Homeless Health Initiatives or other programs that CalOptima operates to provide services to Orange County's homeless population. Determine the amounts budgeted, spent, and remaining for those programs, and whether CalOptima makes this information available to the public.	• Identified the Homeless Health Initiatives that CalOptima operates to provide services to Orange County's homeless population. We identified additional programs that DHCS launched and CalOptima began implementing in 2022. Because these programs were being implemented during our audit, we did not include them in our review. • Reviewed CalOptima's finance department information and board documents to determine the amounts allocated, spent, and remaining for Homeless Health Initiatives as of June 2022. • Compared the locations of this information on CalOptima's website to best practices for making information transparent.
6	Determine whether CalOptima complies with requirements associated with its receipt of federal and state funding for programs that CalOptima operates to provide services to Orange County's homeless population.	• Determined that CalOptima's Medi-Cal agreements with DHCS do not establish requirements for how the IGT funds it retains are to be used, nor are there requirements in its Medi-Cal agreements with DHCS specific to homeless health programs. DHCS is generally prohibited from directing a managed care plan's expenditures under the contract. • Interviewed staff at CalOptima to verify that CalOptima does not have any additional contracts with DHCS that govern its use of IGT funds. • Reviewed completed audits of CalOptima conducted by other auditors and government oversight agencies, and determined that those audits did not identify or assess requirements specific to CalOptima's Homeless Health Initiatives.
7	Evaluate CalOptima's successes and challenges in meeting the goals of its programs that provide health care services to the homeless population of Orange County.	• Determined the guiding principles of CalOptima's Homeless Health Initiatives. Selected seven initiatives to review based on factors including the amounts allocated and spent for the initiative. • For the initiatives selected, evaluated whether CalOptima established a metric for success and measured the initiative's progress, and if not, determined why. • Interviewed staff and reviewed documentation to identify CalOptima's challenges serving members experiencing homelessness.
8	Determine whether CalOptima provides timely access to care for patients, including the homeless population of Orange County.	• Reviewed CalOptima and DHCS surveys to determine whether CalOptima's providers met standards for timely access to care. • Identified and reviewed CalOptima's efforts to improve access-to-care rates among its providers.
9	Compare CalOptima's executive management turnover rates since 2014 against the turnover rates of other public Medi-Cal managed care plans. Evaluate CalOptima's hiring practices and job requirements and identify the effect that those practices and requirements may have on hiring and retention. Compare CalOptima's salaries and credential requirements to other county organized health systems.	• Reviewed CalOptima's annual organizational charts from 2014 through 2022 to determine executive management turnover rates. • Selected four managed care plans that are comparable to CalOptima, identified and reviewed available information on executive management turnover rates since 2014, and compared them to CalOptima's turnover rates. • Reviewed CalOptima's hiring process for a selection of executive positions filled from 2019 through 2022, and determined whether it aligned with best practices for making employment decisions on the basis of merit. We were unable to determine whether CalOptima's hiring of a board member as its interim CEO violated the Political Reform Act. We were also unable to establish a connection between CalOptima's hiring practices and job requirements and its retention of executives. • Identified CalOptima's salaries and credential requirements for a selection of executive positions and compared them to those of the four managed care plans selected for comparison, which included other county organized health systems.
10	Determine whether CalOptima has established mechanisms for its staff and contractors to report misconduct and whether CalOptima has taken sufficient action to maintain an atmosphere free from fear of retaliation for people using those mechanisms.	• Interviewed staff and reviewed related policies to determine whether CalOptima has mechanisms for its staff and contractors to report misconduct and has prohibitions against retaliation that align with applicable laws and recommended practices. • Reviewed a selection of misconduct reports and their resolutions to determine whether the established mechanisms are being used and whether any reported misconduct was addressed by CalOptima.

	AUDIT OBJECTIVE	METHOD
11	Review and assess any other issues that are significant to the audit.	None identified.

Source: Audit workpapers.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, or recommendations. In the course of this audit we relied on the following data.

To determine the total amounts CalOptima received through IGTs and subsequently retained, we obtained spreadsheets from CalOptima containing summary data of these amounts for fiscal years 2012–13 through 2021–22. We performed dataset verification procedures and electronic testing of key data elements and did not identify any issues. We then compared these data to audited financial reports and data independently provided to us by DHCS and found no material discrepancies. Consequently, we determined these data were sufficiently reliable for the purposes of determining the total amounts of IGT revenue that CalOptima received and retained.

To determine the total amount of CalOptima's IGT and Homeless Health Initiative expenditures, we obtained a spreadsheet from CalOptima containing IGT expenditures for fiscal years 2013–14 through 2021–22. We also obtained a spreadsheet of expenditures during fiscal years 2014–15 through 2021–22 for Homeless Health Initiatives and for some programs that were subsequently designated as such. We performed accuracy testing of IGT expenditures by comparing five selected transactions to underlying documentation and found no material errors. We performed accuracy testing of Homeless Health Initiative expenditures by comparing five selected transactions to underlying documentation and found no material errors. Consequently, we determined these data were sufficiently reliable for the purpose of presenting summary totals of CalOptima's IGT and Homeless Health Initiative expenditures.

To determine the sources of CalOptima's revenues, we obtained data from CalOptima's financial accounting system showing revenues by program and payer for fiscal years 2019–20 through 2021–22. We performed completeness testing of the data by comparing them to CalOptima's audited financial statements for fiscal years 2019–20 through 2021–22 and found no material errors. We were not able to perform this testing for fiscal year 2022–23 because the audited financial statements were not yet available. Because it was not cost-effective to perform accuracy testing given our limited use of these data, we determined the data were of undetermined reliability for the purpose of describing the sources of CalOptima's revenues. Nevertheless, because it was the best source of data available, we present the results of our analysis of these data.

To determine the amounts of state and federal funds that DHCS paid to CalOptima, we obtained two tables generated by DHCS's Capitation Payment Management System (CAPMAN system) showing the amounts of state and federal funds DHCS paid to CalOptima for fiscal years 2019–20 through 2021–22. We interviewed staff knowledgeable about the data, reviewed existing information about the data, and reviewed the data for reasonableness. Given our limited use of these data, it was not cost-effective to perform accuracy or completeness testing. Consequently, we found the data from DHCS's CAPMAN system to be of undetermined reliability for the purpose of presenting the amounts of state and federal funds that DHCS paid to CalOptima. Although this determination may affect the precision of the numbers we present, these data were the best evidence available.

To determine whether CalOptima monitored the use of HHI funds, we obtained multiple spreadsheets and a monthly internal report from CalOptima containing data related to selected Homeless Health Initiatives for different periods within calendar years 2018 through 2022. We interviewed staff knowledgeable about the data, performed dataset verification, and manually reviewed whether key data fields contained logical data. We did not perform accuracy or completeness testing of these data. Because we do not present specific numbers or calculations from these data, we determined that the data were sufficiently reliable for our purposes.

We obtained spreadsheets from CalOptima describing reports of potential misconduct for the purpose of selecting incidents to test whether CalOptima followed its established investigation procedures. We performed dataset verification and reviewed whether key fields included reasonable data. We identified no issues as a result of these procedures. Because of the nature of these data, we were unable to compare them to source documentation or an independent data source to confirm that they were complete. However, because they were the best source of such data available, we used these spreadsheets for the purpose of selecting items for further testing.

We obtained electronic data from the California Health and Human Services Agency's webpage for Medi-Cal managed care capitation rates in county organized health systems. We performed dataset verification and electronic testing of whether key fields included reasonable data. We identified no issues as a result of these procedures. Because we used these data to provide background or contextual information, we did not perform further testing.

We obtained electronic data from Central California Alliance for Health that lists its executives during 2013 and 2014 in order to calculate executive turnover rates during the two years for which it could not provide organizational charts. Because we used these data in a calculation that provides background or contextual information, we determined that a data reliability assessment was not necessary.

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April 7, 2023

Sent via email

The Honorable Grant Parks*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

SUBJECT: 2022-112 — Response to Confidential Draft Audit Report

Dear Mr. Parks:

On behalf of CalOptima Health and our 975,000 members, we appreciate the opportunity to respond to the draft audit report. Since June 2022, you and your dedicated team have undertaken a tremendous effort at the direction of the Joint Legislative Audit Committee, and throughout the course of this audit your staff has exhibited professionalism in every step of the process — thank you.

As noted in the initial engagement letter dated August 4, 2022, CalOptima Health has welcomed this audit and acknowledges the hard work of your office in analyzing data and facts, collaborating with our staff and executives, briefing legislators, and answering questions from the media. As a public agency accountable to our members and the taxpayers, CalOptima Health recognizes the need for top-notch leadership, strategic vision, flexibility and accountability in administering Medi-Cal health insurance benefits to our members. ①

While we understand the audit scope required your office to look back nearly one decade, we cannot speak to all the decisions of past leadership. As such, CalOptima Health cannot fully concur with all the findings and recommendations, as the timeframe of the audit does not account for recent leadership actions over the past year. These actions have been based on our *new* vision and strategic priorities, as approved by current leadership and Board of Directors (Board) in March 2022 and June 2022, respectively. Be assured we are guided by our mission to provide members with dignified and comprehensive health care along with measurable outcomes.

As noted in this response, CalOptima Health has already rectified many of the changes subsequently recommended in the audit and did so prior to the audit findings and recommendations being finalized. In addition, CalOptima Health and its Board have made additional significant investments with our providers and community partners that continue to address access to care and homelessness — including a street medicine program specifically designed to address the medical needs of unhoused individuals living on the streets of Orange County that launched on April 3, 2023. ②

* California State Auditor's comments begin on page 49.

We are committed to delivering the mission and the vision of CalOptima Health in order to best serve our members. That means committing ourselves to improvement every day. Thank you again for the efforts put forth by the audit team and the professional collaboration.

Finding #1: CalOptima Has Accumulated Surplus Funds It Should Have Used To Improve Services

Acknowledgment #1: CalOptima Health partially concurs with the findings.

③ As the report notes, CalOptima Health has drastically accelerated its allocation of surplus funds since Michael Hunn became interim Chief Executive Officer in November 2021. This has included major updates to our infrastructure and funding programs specifically targeted to Orange County's most vulnerable. Leadership will continue to evaluate more opportunities with our providers and community partners and identify additional programs on which to prudently spend our taxpayer funds. Aggregated, CalOptima Health has newly allocated $262.5 million to be spent on programs in fiscal year (FY) 2021–22. Another $285.4 million has been allocated since July 2022 after the audit review period.

Some key initiatives funded since FY 2021–22, along with their total program costs, are listed below:

- **$153.5 million**: Five-year hospital quality program
- **$108.1 million**: COVID-19 supplemental payments to health networks and qualified providers
- **$100.0 million**: Digital transformation and workplace modernization strategy
- **$50.1 million**: Five-year comprehensive community cancer screening and support program
- **$50.0 million**: Five-year grant to community health centers
- **$40.1 million**: Housing and Homelessness Incentive Program grant funding
- **$25.0 million**: Medi-Cal and OneCare pay-for-value programs
- **$19.9 million**: Applied Behavioral Analysis provider rate increases
- **$15.0 million**: Be Well OC investment towards forthcoming Irvine campus
- **$15.0 million**: Medi-Cal annual wellness visit initiative
- **$10.0 million**: Three-year skilled nursing facility access program
- **$8.0 million**: Street medicine program
- **$7.0 million**: Orange County Health Care Agency outreach and engagement team
- **$5.0 million**: Five-year National Alliance for Mental Illness peer support program
- **$4.3 million**: Mental health provider rate increases
- **$4.1 million**: Skilled nursing facility rate increase
- **$2.0 million**: CalFresh enrollment outreach
- **$2.0 million**: Two-year in-home care pilot program
- **$1.0 million**: Be Well OC grant for intake and admissions coordination at Orange campus
- **$1.0 million**: Medicare member incentive program
- **$0.7 million**: Homeless Clinical Access Program extension

④ CalOptima Health currently has a Board-designated reserve policy that the Board will review to ensure it includes processes for evaluating surplus funds as well as their general uses. Specifically, CalOptima Health's three-year strategic plan and annual budget processes are the appropriate venues for the Board to determine organizational priorities and consider the detailed uses and allocations of those funds. As unanticipated needs and opportunities arise, the Board also takes separate actions throughout the year to

use surplus funds. Together, these satisfy the requirements of the county ordinance to develop a financial plan regarding the expenditure of surplus funds. An additional, separate financial process would cause duplication and potential misalignment. As acknowledged in the report, whenever CalOptima Health has spent surplus funds, it has always been consistent with the recommended purposes of expanding access, improving benefits or augmenting provider reimbursement. ④ ⑤

However, it would not be fiscally prudent for CalOptima Health to continuously spend down unallocated surplus funds in their entirety to the current reserve requirement of two months within a recurring defined period (e.g., 12 months). As a government agency, it would be poor practice to meet only minimum thresholds. To wit, when the State of California has historically been unable to pass a budget, the Department of Health Care Services (DHCS) failed to pay Medi-Cal managed care plans. Further, Medicaid funding has been recouped in the past due to overpayments by the federal government. If CalOptima Health were ever to experience insolvency, taxpayers would foot the bill — not the state or federal government. As of February 2023, our Board-designated reserves and unallocated fund balance only represent approximately 101 total days of cash on hand. ⑥

Finding #2: CalOptima Retained A Larger Share Of IGT Funds Than Other Managed Care Plans

Acknowledgment #2: CalOptima Health concurs with the findings.

As affirmed by the report, in August 2022, CalOptima Health reduced its percentage of retained intergovernmental transfer (IGT) funds from 50% to 2%, or less, of federal matching funds received by DHCS. Also, CalOptima Health has successfully allocated all remaining IGT funds it had previously retained, as of December 2022. While we understand the audit reviewed evidence at a point in time in June 2022, CalOptima Health appreciates the report noting these additional developments as well as confirming that there are no further recommendations related to its IGT process.

Since launching its Homeless Health Initiatives (HHI) in 2019, CalOptima Health has been an innovator in exploring how a health plan can take a more proactive, voluntary role in joining community efforts to address homelessness. CalOptima Health is incorporating trackable goals and metrics into all its current and future HHI. CalOptima Health supports a member-focused, metric-driven approach in support of our mission to serve members — including those who are unhoused — with excellence and dignity, respecting the value and needs of each person. Therefore, CalOptima Health will also implement a written policy that incorporates these best practices.

Finding #3: CalOptima Did Not Follow Best Practices When Hiring For Some Executive Positions

Acknowledgement #3: CalOptima Health concurs with the findings.

As recommended in the report, CalOptima Health will add a new hiring policy to complement the current, prescriptive hiring process and which will incorporate additional best practices. The Board is expected to approve this “Recruitment, Selection, and Hiring” policy at its regular meeting on May 4, 2023. CalOptima Health had already established minimum position requirements and a systematic approach to compensation developed from the findings of a third-party compensation survey conducted in 2018. We expect to conduct a new survey in 2024. Most importantly, the recent alignment of ⑦

compensation with current market rates has, by design, decreased our year-to-date turnover rates to 10.0% for executives and 10.3% for all employees, despite a highly competitive job market.

CalOptima Health acknowledges that, when appointing the interim CEO #2 in April 2020, its Board — at that time — may have failed to observe the provisions specified in Government Code section 1090, as a result of previous in-house legal counsel concurring with the action and the Board relying on such
(8) concurrence. Nonetheless, the current Board reiterated the requirements of Government Code section 1090 into its bylaws, as recommended in the audit report, at its regular meeting on April 6, 2023.

Finding #4: Efforts To Investigate Reports Of Misconduct And Ensure An Atmosphere Free From Retaliation

Acknowledgment #4: CalOptima Health partially concurs with the findings.

Every allegation of misconduct and fraud, waste and abuse (FWA) received by CalOptima Health is
(9) taken seriously and reviewed in detail. Regarding the case described in the report, CalOptima Health "determined the allegation had no relation to CalOptima" because CalOptima Health researched the issue and determined the person reporting the issue and any other associated parties did not reside in the CalOptima Health service area and were not CalOptima Health members.

CalOptima Health takes all allegations of potential impropriety or misconduct seriously and makes every effort to understand what is being alleged. Most cases with insufficient information simply do not have enough information to formally investigate. Attempts are always made to reach individuals reporting such allegations. However, in many cases there is limited opportunity to reach them because they either do not answer or return calls, or they have reported the allegation anonymously and decline
(9) to provide further information when contacted for follow-up. Whenever allegations can be investigated, they are always investigated under strict, formal processes. Nonetheless, as recommended in the report. CalOptima Health will update its written policy to clarify all current processes.

CalOptima Health has a strong vested interest in any allegations of potential misconduct, FWA and retaliation. In addition to information on the CalOptima Health website about our several reporting channels, we are providing the CalOptima Health Compliance and Ethics Hotline number here for anyone who wishes to make a report: **1-855-507-1805** (TTY **711**). Issues can be reported 24/7/365 and can be done so anonymously at the preference of the caller.

In addition, CalOptima Health has not identified any patterns of retaliation, and in the limited cases when allegations have been received, swift action was taken. CalOptima Health has a strict anti-retaliation policy that is followed in every case. Every Board member and employee of CalOptima Health — at all levels — is required to complete annual compliance trainings related to misconduct, FWA and retaliation. Not completing such trainings results in disciplinary actions, including up to termination of employment or dismissal from the Board. Nevertheless, CalOptima Health acknowledges
(10) that there is always opportunity to improve understanding of current policies and therefore launched an employee survey on March 31, 2023, ahead of the recommendation in the report.

Finding #5: Actions to Improve Timely Access to Care for CalOptima Members

Acknowledgement #5: CalOptima Health concurs with the findings.

As confirmed in the report, since CalOptima Health previously addressed these findings, there are no recommendations to implement. CalOptima Health works closely with all contracted providers to advance timely access to care for our members.

Finding #6: Accessibility of Financial Information on CalOptima's Website

Acknowledgement #6: CalOptima Health concurs with the findings.

As confirmed in the report, since CalOptima Health previously addressed these findings, there are no recommendations to implement. Detailed financial information, including operating and capital budgets, audited financial statements and monthly financial summaries, are linked to the home page of the CalOptima Health website. (11)

Thank you again for the opportunity to respond to the draft audit report. If you have any questions regarding the contents of this response, please do not hesitate to contact us.

Sincerely,

Michael Hunn	Clayton M. Corwin	Blair Contratto
Chief Executive Officer	Chair, Board of Directors	Vice Chair, Board of Directors

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM CALOPTIMA HEALTH

To provide clarity and perspective, we are commenting on the response to our audit from CalOptima. The numbers below correspond to the numbers we have placed in the margin of the response.

To clarify, as we informed CalOptima when we began our work, all substantive information relating to a pending audit report is confidential. Upon approval of the request for this audit by the Audit Committee, we became subject to requirements in state law governing our authority to disclose information about the audit. Thus, from then until we issued the report, we did not brief members of the Legislature or answer questions from the media. ①

CalOptima's response is misleading. We did not make recommendations to address findings that CalOptima proved it had already resolved. When CalOptima provided us evidence that it had addressed a problem we identified, we assessed that evidence and did not make a recommendation if further corrective action was not warranted. Thus, the recommendations contained in this report pertain to findings that CalOptima has not yet proven it has resolved. ②

CalOptima's description of our report could be misleading. We did not assess whether CalOptima's allocation of surplus funds has drastically increased since November 2021. We did include a statement from the CEO on CalOptima's allocations of surplus funds; however, this is the CEO's statement and not our conclusion. As Table 2 on page 10 shows, CalOptima's surplus funds increased by $102 million in fiscal year 2021–22. Further, as we describe beginning on page 11, allocations alone will not reduce CalOptima's surplus. CalOptima must spend what it has allocated. If it struggles to spend the surplus funds it has allocated, as it has in the past, the surplus may continue to grow. ③

We disagree with CalOptima's statement that its three-year strategic plan, annual budget, and board actions to use surplus funds have satisfied the requirements of the county ordinance. As we state on page 8, the county ordinance that requires CalOptima to implement a financial plan also requires the plan to provide that if additional surplus funds accrue, those additional funds shall be used to expand access, improve benefits, or augment provider reimbursement, or for a combination of those purposes. This requirement has been in a county ordinance for nearly 30 years, but CalOptima has not fulfilled it: its reserve policy does not address the requirement; its strategic plan for 2020 to 2022 does not describe allocations of the surplus funds it has retained; its annual budgets have resulted in an increase in its surplus, as Figure 2 illustrates; and despite the actions of its board, there were hundreds of millions of dollars of surplus funds for which CalOptima had not even defined a purpose, as we describe on page 12. Moreover, we believe that CalOptima's concerns about a potential duplication of effort are overstated. CalOptima could implement our recommendation to address this requirement as part of its annual budget process. ④

⑤ Our report does not acknowledge, as CalOptima states, that whenever it has spent surplus funds, it has always been consistent with the purposes described in the county ordinance. At CalOptima's request, we describe on page 11 the CFO's belief that when CalOptima does spend surplus funds, it has spent them for the purposes that the county ordinance specifies. However, this is the CFO's perspective, not our conclusion.

⑥ CalOptima's response contradicts statements it made to us during the course of the audit that we reference in the report. According to CalOptima's CFO, the board-designated reserve level is sufficient to meet regulatory requirements and to allow CalOptima to meet its obligations in the event of unexpected circumstances, as we describe on page 8. Nevertheless, if CalOptima now believes that it would not be fiscally prudent to spend all of its current surplus funds, it should revise its reserve policy to reflect the amount that it determines is fiscally prudent to keep in reserve and, in accordance with the requirements in county ordinance, spend the remaining funds for the benefit of individuals who are eligible to receive care from CalOptima.

⑦ CalOptima's assertion that it currently has a prescriptive hiring process does not align with the evidence we reviewed. As we describe on page 26, according to CalOptima's HR chief, CalOptima does not have a written hiring policy and to the best of her knowledge has never had one. Further, as Table 4 on page 27 illustrates, even if the practices described to us by the HR chief were considered to be prescriptive, CalOptima has not followed them. Implementing our recommendation would allow CalOptima to establish a prescriptive process.

⑧ CalOptima's response mischaracterizes our recommendation on page 28. We did not recommend that CalOptima reiterate the requirements of Government Code section 1090 in its bylaws. We recommended that it amend its bylaws to prohibit all CalOptima board members from being employed by CalOptima for a period of one year after their term on the board ends. The public agenda for CalOptima's board meeting on April 6, 2023, demonstrates that CalOptima has not yet implemented the recommendation.

⑨ CalOptima's comments do not address the weaknesses we identified with its process for handling allegations of fraud, waste, and abuse, and its explanation of why it concluded a specific allegation did not relate to CalOptima is irrelevant. CalOptima did not report its findings to DHCS as DHCS directed and as CalOptima's established procedures for investigating allegations would have required. As we explain on page 29, CalOptima described its response to nearly 78 percent of allegations of fraud, waste, and abuse—and nine of the 10 allegations we reviewed—as monitoring activities, not investigations. Although CalOptima now asserts that allegations are always investigated under strict, formal processes whenever they can be investigated, we found that CalOptima has not specified the types of allegations that should be monitored versus investigated or established formal procedures for allegations it addresses through monitoring activities. As noted on page 30, this presents a risk that CalOptima will not handle all allegations appropriately, as we found for the specific allegation CalOptima's response references.

CalOptima did not provide us with the survey it states that it performed in March 2023—after we met with CalOptima leadership to describe the results of our audit work. We look forward to assessing CalOptima's attempt to better understand how employees perceive its anti-retaliation efforts when it provides us with evidence of the survey as part of its update on the status of its efforts to implement our recommendations. (10)

CalOptima's response suggests that it has linked multiple budgets, audited financial statements, and monthly financial summaries to its home page. However, as of April 2023, CalOptima had posted links only to its budget for fiscal year 2022–23, its audited financial statements for fiscal year 2021–22, and its financial summary for March 2023. We encourage CalOptima to post links to additional detailed financial information—such as budgets and financial statements from prior fiscal years—so that the public may access that information more easily. (11)