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

THURSDAY, JULY 14, 2016
2:30 P.M.

CALOPTIMA
505 CITY PARKWAY WEST, SUITE 109-N
ORANGE, CALIFORNIA 92868

AGENDA

This agenda contains a brief, general description of each item to be considered. The Committee may take any action on all items listed. Except as otherwise provided by law, no action shall be taken on any item not appearing in the following agenda.

Information related to this agenda may be obtained by contacting the CalOptima Clerk of the Board at 714.246.8806 or by visiting our website at www.caloptima.org. In compliance with the Americans with Disabilities Act, those requiring special accommodations for this meeting should notify the Clerk of the Board's office at 714.246.8806. Notification at least 72 hours prior to the meeting will allow time to make reasonable arrangements for accessibility to this meeting.

I. CALL TO ORDER
Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES
A. Approve Minutes of the May 12, 2016 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC)

IV. PUBLIC COMMENT
At this time, members of the public may address the Committee on general topics. Public Comment on posted item(s) will follow staff presentation of the item(s) to the Committee. If you wish to speak on an item contained in the agenda, please complete a Public Comment Request Form(s) identifying the item(s) and submit the form to the assistant to the MAC. When addressing the Committee, it is requested that you state your name for the record. Please address the Committee as a whole through the Chair. Comments to individual Committee members or staff are not permitted. Speakers will be limited to three (3) minutes.

V. REPORTS
None

VI. PRESENTATIONS

A. Presentation by Easter Seals of Southern California

VII. CEO AND MANAGEMENT REPORTS

A. Chief Executive Officer (CEO) Report
B. Chief Medical Officer Update
C. Chief Operating Officer Update

VIII. INFORMATION ITEMS

A. MAC Member Updates
B. Health Network Minimum Enrollment Requirement
C. Health Education and Cultural and Linguistic Group Needs Assessment (GNA)
D. California Children's Services Redesign Update
E. Intergovernmental Transfer Update
F. Federal and State Legislative and Budget Update

IX. COMMITTEE MEMBER COMMENTS

X. ADJOURNMENT

MINUTES

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

May 12, 2016

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on May 12, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Mallory Vega called the meeting to order at 2:40 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Mallory Vega, Chair; Suzanne Butler; Sandy Finestone; Connie Gonzalez; Donna Grubaugh; Gene Howard; Stephanie Martinez; Gregory Mathes; Sally Molnar; Christina Sepulveda; Velma Shivers; Lisa Workman

Members Absent: Victoria Hersey; Patty Mouton; Sr. Mary Therese Sweeney

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Javier Sanchez, Chief Network Officer; Candice Gomez, Executive Director, Program Implementation; Richard Bock, Deputy Chief Medical Officer; Arif Shaikh, Director, Government Affairs; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the November 12, 2015 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

Approve the Minutes of the January 21, 2016 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee and Provider Advisory Committee

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

Chair Vega recognized Member Gregory Mathes, whose term expires on June 30, 2016, for his service to the MAC since 2004.

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Approval of Fiscal Year (FY) 2015-2016 MAC Accomplishments
Chair Vega presented the MAC's FY 2015-2016 Accomplishments for approval, which she will present to the CalOptima Board at the June 2, 2016 meeting.

Action: ***On motion of Member Sandy Finestone, seconded and carried, MAC approved the FY 2015-2016 Accomplishments as submitted.***

Consider Approval of FY 2016-2017 MAC Meeting Schedule
Chair Vega presented the FY 2016-2017 meeting schedule for approval.

Action: ***On motion of Member Stephanie Martinez, seconded and carried, MAC approved the FY 2016-2017 MAC Meeting Schedule as submitted.***

Consider Approval of FY 2016-2017 MAC Goals and Objectives (G&O)
Chair Vega reported the MAC G&O Ad Hoc, composed of Connie Gonzalez, Gene Howard and Gregory Mathes, met on April 20, 2016 to review the FY 2016-17 G&O.

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC approved the FY 2016-2017 MAC Goals and Objectives as submitted.***

Recommendation of FY 2016-2017 MAC Slate of Candidates and Chairperson
Chair Vega announced that the Board of Directors has requested additional information on the nominations and recommendations of individuals for appointment to the committee. To that end, a list of all candidates or nominees for each position, a short biography on each candidate or nominee and the Nominations Ad Hoc Subcommittee's recommendation of appointees will be presented to the Board for consideration at the June Board meeting.

Member Sandy Finestone reported on the Nominations Ad Hoc Subcommittee's recommended slate of candidates and Chairperson. The Ad Hoc convened on April 20, 2016 and included Members Connie Gonzalez, Suzanne Butler and Sandy Finestone. After reviewing the applications and selecting a candidate for each seat, the Nominations Ad Hoc recommended the following slate of candidates: 1) Christina Sepulveda as the Children's Representative; 2) Lisa Workman as the Consumer Representative; 3) Gene Howard as the Foster Children Representative; 4) Velma Shivers as the Long-Term Care Representative; 5) Sally Molnar as the Medically Indigent Persons Representative; 6) Sister Mary Therese Sweeney as the Persons with Mental Illness Representative; and 7) Christine Tolbert as the Persons with Special Needs Representative.

Action: ***On motion of Member Sandy Finestone, seconded and carried, MAC approved the recommended slate of candidates as presented .***

Member Finestone reported that the Nomination Ad Hoc recommended the appointment of Mallory Vega as FY 2016-2017 MAC Chair.

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC approved the 2016-2017 Chairperson as recommended.***

Consider Recommending Board of Directors' Addition of Vice Chair Position to Member Advisory Committee

Chair Vega reported that the Provider Advisory Committee (PAC) recently voted to recommend to the Board of Directors the addition of a Vice Chair position to the PAC. This request will now go to the Board of Directors for consideration. Chair Vega noted that the Vice Chair would fill in if the Chair were unavailable.

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC recommended Board consideration of the addition of a Vice Chair to MAC.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported that CalOptima is preparing for a Medi-Cal Expansion (MCE) rate reduction. The proposed rates for the MCE population, about one-fourth of CalOptima's overall Medi-Cal membership, will be a fifteen percent reduction. Mr. Schrader noted that these rates, while lower than the current MCE rates, are based on input from the state. He added that CalOptima would continue to advocate for appropriate MCE and Medi-Cal Classic rates through our associations and our ongoing communications with the Department of Health Care Services (DHCS). If CalOptima is successful in obtaining higher rates, CalOptima will pass these along to our provider partners. Mr. Schrader noted that to ensure CalOptima's provider network is in place on July 1 for the start of FY 2016-17, it is important to send contract amendments now to the health networks, hospitals and specialists rather than wait for final rates. He explained that executing the amendments can take several weeks, and final rates are subject to approval by the Centers for Medicare & Medicaid Services (CMS). He added that the providers have received sufficient communication about this upcoming rate change.

Mr. Schrader reported that the Legacy Awards event was held at the Bowers Museum on April 21, 2016. This event drew the community together to celebrate CalOptima's 20th anniversary and the collective commitment to improving the lives of Orange County's vulnerable residents.

Chief Medical Officer Update

Richard Bock, MD, Deputy Chief Medical Officer, reported on CalOptima's minimum physician standards for all physicians newly credentialed either by CalOptima or its delegated networks. It requires that contracted physicians be board certified in their specialty. Dr. Bock explained the following proposed standards: 1) applicants can have no felony convictions within 10 years prior to applying; 2) physician applicants must not be on probation for any reason; and 3) applicants must not have an accusation pending before their licensing board. He added that an accusation is not a malpractice allegation. An accusation is a legal document from the Medical Board of California (MBC) that begins with a formal disciplinary process after an investigation finds evidence that the

physician has violated disciplinary action. An accusation lists the changes and/or the section of law alleged to have been violated and is served on the physician.

Dr. Bock reported on the rampant growth of opioid use since 2000. This nation-wide problem caused more deaths from opioid overdoses last year than traffic accidents with over 290 million prescriptions written annually. Dr. Bock reported that CalOptima is tracking opioid utilization and working with physicians and pharmacies to track and monitor opioid prescriptions. CalOptima sends any findings to the Medi-Cal investigative unit when someone is prescribed more than 1,000 pills in a 90-day period.

Chief Network Officer Update

Javier Sanchez, Chief Network Officer, reported that CalOptima is working with Dr. Donnelly at the Center for Autism and Neurodevelopmental Disorders to minimize the backlog of children in Orange County that are waiting for an autism screening and diagnosis. Dr. Donnelly and his group developed curriculum to train physicians, primarily pediatricians, to conduct the screening and diagnosis. Mr. Sanchez noted that CalOptima is using Intergovernmental Transfer (IGT) funds to support a provider incentive program that pays physicians as an incentive to take the training. To date, 30 physicians have enrolled for the first six-week session.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that CalOptima mailed over 1,900 application packets to members who have Medicare Part B only to determine if they qualify for the Qualified Member Beneficiary (QMB) program. The QMB program pays premiums, deductibles and co-insurance for Medicare Part A for members who are eligible, but have limited income and resources. Ms. Khamseh noted that CalOptima had a 48% return rate. If a member qualifies, QMB benefits start July 1, 2016. Once members have this additional coverage, they would qualify for OneCare or OneCare Connect programs.

Ms. Khamseh reported that with the passage of Senate Bill 75, children under 19 years of age would become eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements. This population transitions into full-scope Medi-Cal, effective May 16, 2016, and enrolls with CalOptima on June 1, 2016.

Ms. Khamseh reported that CalOptima is working with the Orange County Health Care Agency (HCA) on the transition of California Children Services (CCS) to CalOptima. She noted that CalOptima's transition will begin no earlier than July 1, 2017, and will be contingent upon a readiness review conducted by DHCS.

Ms. Khamseh reminded the committee that only two months remain of passive enrollment for the OneCare Connect program. After July, members will have to enroll voluntarily into OneCare Connect.

INFORMATION ITEMS

Medi-Cal Call Center

Hellen Howe, Medi-Cal Program Deputy Director, Social Services Agency (SSA), provided an overview on the SSA Medi-Cal Call Center assistance program. Ms. Howe explained that SSA implemented the Call Center in 2010 to respond to increasing customer volume and to enhance accessibility to services. She noted that Call Center activity has risen 80% in the last five years requiring SSA to transition to an updated platform to increase efficiency and enhance service delivery options. Ms. Howe outlined several strategies to improve customer service, such as monitoring wait times to identify staffing needs, providing callers with a callback option, conducting random supervisory call reviews, and recording calls for quality assurance.

Member Experience Update

Kelly Rex-Kimmet, Director of Quality Analytics, reported on an update on the Member Experience Work Group. The goal of the work group is to implement strategies to raise member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which impacts the National Committee of Quality Assurance (NCQA) accreditation and national ratings. The work group activities include: analyzing CAHPS results and identifying areas for member improvement; conducting a supplemental survey to members; releasing a request for information (RFI) to gather market intelligence on methods to gather further member experience data; conducting customer service post-call surveys; and implementing process improvements at CalOptima and with our health networks. The findings from the supplemental survey identified the following sources of member dissatisfaction: coordination of care; access to specialist care; communication with provider; length of time to get an appointment; and length of time in the waiting room at the appointment. CalOptima will continue member experience initiatives and analysis to identify and reduce member issues.

Federal and State Budget and Legislative Update

Arif Shaikh, Director, Government Affairs, announced that Governor Brown is expected to release his May Revision to the FY 2016-17 State Budget proposal later this week. The May Revise represents the last formal outline of the administration's funding priorities for the next fiscal year, which begins July 1, 2016. Mr. Shaikh reported that the Governor's January budget proposal included the continuation of the Coordinated Care Initiative (CCI), which includes OneCare Connect; however, an extension beyond 2017 would be contingent upon the program achieving greater financial sustainability through increased enrollment. DHCS has proposed CCI program improvements to strengthen Cal MediConnect, including improvement in care coordination, sharing best practices and engaging in outreach to providers in order to reduce opt-out rates. In addition, DHCS is keeping open the possibility of instituting a passive enrollment process in 2017.

Mr. Shaikh announced that the Dental Transformation Initiative (DTI), a program authorized by California's new §1115 Waiver, is designed to increase access to dental care.

ADJOURNMENT

Hearing no further business, Chair Vega adjourned the meeting at 5:00 p.m. The next MAC meeting is scheduled on July 14, 2016 at 2:30 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: July 14, 2016

Easter Seals
DISABILITY SERVICES

Easter Seals Brand Renaissance

Why a Brand Renaissance? (Objectives for Success):

- ✓ **Sharpen our identity and communicate importance of what we do**
- ✓ **Unify our national brand**
- ✓ **Resolve the name issue and contemporize our image**
- ✓ **Differentiate from other organizations**
- ✓ **Resolve ambivalence over "disabilities"**
- ✓ **Provide basis for raising awareness and visibility**

Bring clarity and greater relevancy to our brand and position Easter Seals for its next 100 years.

The opportunity – We are closely linked to one key word

What single word is most closely associated with Easter Seals?

#1 Disability (101)

#2 Service/ Services (25)

#3 Children (20)

#4 Help (7)

#5 Compassion (6)

Easter Seals brand differentiation

Heart disease

Veterans

Autism

Breast cancer

Disabilities

Babies

Communities

Work

Alzheimer's

Behind our new brand is one simple idea:

REDEFINING DISABILITIES FOR TODAY'S CHALLENGES

"I want to live in a world where disability is not the exception, but the norm."

– Stella Young, TED talk April, 2014

What does it mean to “redefine disabilities?”

from	to
Visible, physical conditions	Including invisible, emotional, social and educational challenges
A limitation	Being a part of normal, everyday life that can be managed
Only affecting “other” people	A word that defines a barrier, not a person
A word that labels people	A condition that touches all of us and our families at some point

How do we align communications with our new brand strategy?

Broaden the relevance of disabilities

Any and all of us will be touched by disabilities in our lives.

Assert Easterseals' leadership

…in all aspects of understanding and addressing 21st-century disabilities.

Take the sting out of the term

It's a part of life.

Help the world take a second look at people with disabilities

…and appreciate the abilities of people who live with them.

OUR NAME


easterseals

OUR PURPOSE, TAGLINE AND POSITIONING

OUR PURPOSE STATEMENT

To change the way the world defines and views disabilities by making profound, positive differences in people's lives every day.

"DEFINES"

Dispels stereotypes. Shapes the terms of the debate.

"VIEWS"

Challenges attitudes and perceptions – both of society and in our own lives.

"BY MAKING PROFOUND, POSITIVE DIFFERENCES IN PEOPLE'S LIVES EVERY DAY."

The benefit.

Getty Images 494158036

OUR TAGLINE

Taking on disability together

“TAKING ON”

Owning and actively facing this issue, day in and day out.

“DISABILITY”

Reminds the world of our cause, expertise and leadership.

“TOGETHER”

Speaks to our collaborative work across affiliates, within the community, and alongside the people we serve.

OUR POSITIONING STATEMENT

For nearly 100 years, Easterseals has been the indispensable resource for people and families challenged by disability.

Now, as America faces a broad range of new issues, we make a major, positive, life—changing difference in the lives of people and families challenged by today's disabilities. The work we do every day is redefining disability for the 21st century.

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easterseals
taking on disability together


easterseals
Southern California


easterseals
Capper Foundation
taking on disability together

easterseals
taking on disability together

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Chicago, Illinois 60606-4803
p: 312.726.6200
tdd: 312.726.4258
fax: 312.726.1494
easterseals.com

To Whom It May Concern,

Temporporro qui que sinullat.Ebitio cusam sequas aut explisti officabo. Adis verumquam et endis nimusanit quia quae mil il modis sunt aut es esequas et anisquiatur simentem nonet omnis et aut dolorem utet, comni ut optatum ex et eari.

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Sincerely,

C. Sample

Chris A. Sample
Senior Vice President

easterseals

Brand Guidelines

IMPLEMENTATION

Brand Renaissance

BRAND IS MORE THAN A LOGO…

IT'S A KEY COMPONENT OF OUR FUTURE…

Brand Renaissance

IN FACT, IT'S AN ESSENTIAL FOUNDATION FOR OUR NEXT 100 YEARS…

ENABLING EASTERSEALS TO EVOLVE AND THRIVE AS A RELEVANT AND COMPELLING ORGANIZATION AND CAUSE.

A 21st Century Easterseals built on…

- Strong brand presence driving:
  - Increased awareness
  - Increased philanthropy & investment
  - Increased service reach & impact
- First class experience across society in all we do
- Data-driven strategies that enhance philanthropy, service excellence & business opportunities
- Governance structure, policies and processes that assure success in a challenging environment
- Collaboration throughout the network that leverages collective strengths and advances shared goals

easterseals

…and, above all, committed…

To change the way the world defines and views disabilities by making profound, positive differences in people's lives every day.

easterseals


easterseals
taking on disability together

Health Network Minimum Enrollment Requirement

Ladan Khamseh, Chief Operating Officer

Lizeth Granados, Director, Provider Network Management

PAC Discussion

At its 4/14/16 and 6/9/16 meetings, CalOptima's Provider Advisory Committee (PAC) discussed CalOptima Medi-Cal Policy EE.1106, *Health Network (HN) and CalOptima Community Network (CCN) Minimum and Maximum Enrollment*, which applies to Medi-Cal only and requires

- HNs and CCN to maintain an enrollment of at least 5,000 members following the first 12 months after initial member enrollment

Background

- In February 2013, the CalOptima Board of Directors (Board) authorized staff to explore options to expand CalOptima's delivery system by adding HNs through a Request for Proposal (RFP) process

- The expansion initiative resulted in the addition of three new HNs
  - Orange County Advantage (OCA) – went live on 9/1/15
  - Heritage Provider Network (HPN) – went live on 12/1/15
  - St. Joseph Hoag Heritage Health (SJHH) – anticipated to go live in 2016

Background (Cont.)

- CalOptima's minimum enrollment requirement is designed to ensure the viability of HNs, support administrative efficiencies and stabilize the delivery system

- The Board has recognized that there are circumstances that necessitate adjustment of the minimum enrollment requirement in order to accommodate changes to health care needs or the delivery system
  - In the past 10–12 years, depending on unique circumstances, the Board has considered adjusting this requirement based on CalOptima need

Discussion

- The RFP and HN expansion process was implemented over two years and required more time to complete than originally anticipated

- New HNs that expand the make-up and breadth of CalOptima's provider network may also require additional time to address factors that influence membership growth
  - CalOptima's auto assignment allocation and ranking do not consider a new HN's quality scores until after a full calendar year of operation
  - New HNs and/or HNs new to Orange County may lack the market footing or name recognition compared with larger, more established HNs

Discussion (Cont.)

- Staff reviewed OCA's and HPN's membership growth plans
  - Based on their plans to expand access and maintain member and provider satisfaction through outreach, engagement and recruitment, they are on the right track to meet the minimum enrollment requirement
  - However, additional time may be necessary to achieve the minimum enrollment requirement

- OCA and HPN are currently in good standing operationally

Next Steps

- Provider Advisory Committee (PAC) discussion and recommendation to the Board to extend the timeframe to a maximum of 30 months, while allowing the CEO flexibility to do so based on the health network's performance and meeting operational requirements

- Member Advisory Committee's (MAC) review and discussion of the minimum enrollment requirement timeline

- Based on MAC and PAC recommendations, staff may prepare a CalOptima Board Action Agenda Referral (COBAR) for consideration at the Board's August 4, 2016, meeting

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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Health Education and Cultural and Linguistic Group Needs Assessment

Board of Directors' Member Advisory Committee

July 14, 2016

Pshyra Jones

Director, Health Education & Disease Management

Background

Health plans are required to conduct Group Needs Assessments (GNAs) to identify the needs of members, available health education and cultural and linguistic (C&L) programs and resources, and gaps in services.

The special needs of seniors and persons with disabilities, children and adults with special health care needs, members with limited English proficiency, and members from diverse cultural and ethnic backgrounds must be specifically addressed in the GNA findings.

Information Source: Department of Health Care Services (DHCS)

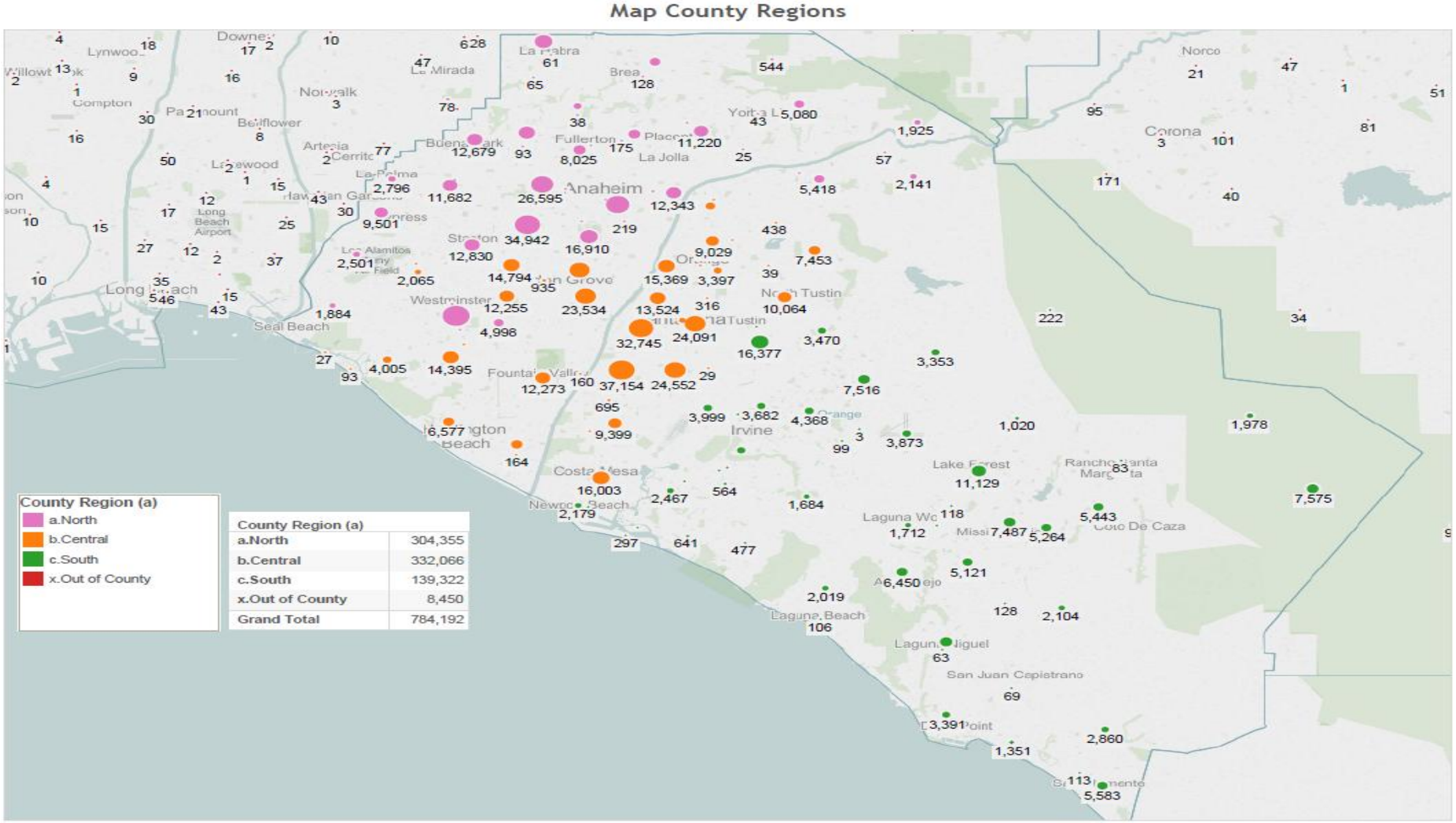
Goal

The goal of the GNA is to improve health outcomes for members enrolled in Medi-Cal managed care by evaluating Medi-Cal managed care member health risks, identify health needs, and prioritize health education, C&L services, and quality improvement programs and resources to improve members' health outcomes.

DHCS Required Sample Size

Required	Min # Completed Surveys	Membership Proportion	Sample Size(4X)
English	230	0.560	920
Spanish	115	0.280	460
Vietnamese	41	0.100	164
Korean	12	0.029	48
Farsi	6	0.015	24
Arabic	4	0.010	16
Chinese	3	0.007	12
Total	**411**	**100%**	**1,644**

CalOptima Medi-Cal Membership by Region



CalOptima Required Sample Size

Language	Target # Returned/Region	X3Regions	X4(Expected 25% Return)
English	200	600	2400
Spanish	200	600	2400
Vietnamese	200	600	2400
Korean	200	600	2400
Farsi	200	600	2400
Arabic	200	600	2400
Chinese	200	600	2400
Total	**1,400**	**4,200**	**16,800**

Sample Size Summarized

- Mail 18,444 surveys
- Expect a minimum of 2,611 responses
  - Double-check we have health network coverage across regions…
- With that, we can compare:
  - Language difference within or between regions
  - Health network difference between regions
  - Health network difference between languages
  - Comparisons between Orange County districts
    - All within +/- 7% confidence interval

But What Else…

- Included custom questions to address categories representing social determinants of health

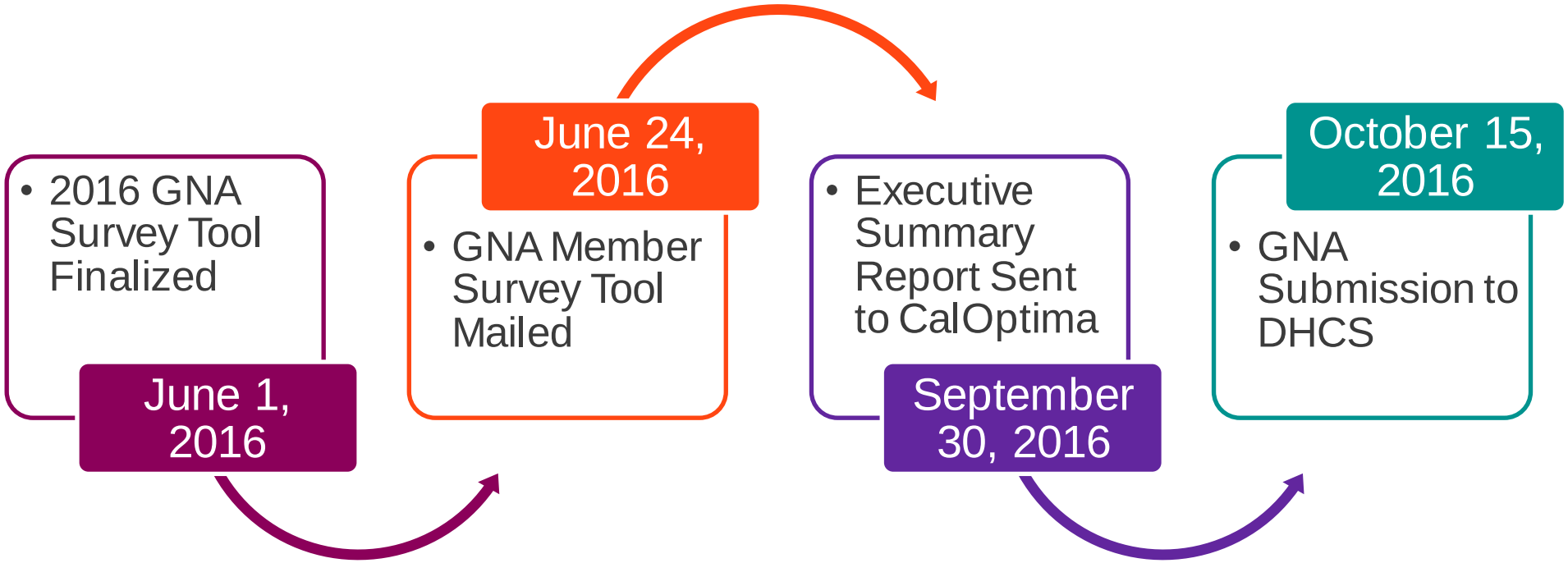
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Proposed Member Incentive Strategy

- Series of opportunity drawings for the following:
  - Family packs to Disneyland/Disney California Adventure
  - Knott's Berry Farm tickets
  - Family packs to Boomers Golf, Go Karts and More
  - Annual parking passes for county, regional wilderness and beach parks

GNA Timeline



After the Survey…

- Evaluate data for health-related trends within the community.
  - Strengthen assets
  - Problem-solve deficits
- Identify areas for collaboration and cooperation among:
  - Providers
  - Community agencies
  - Members
  - CalOptima
- Develop short-term and long-term action plans.

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California Children's Services (CCS): Whole Child Model

Member Advisory Committee

July 14, 2016

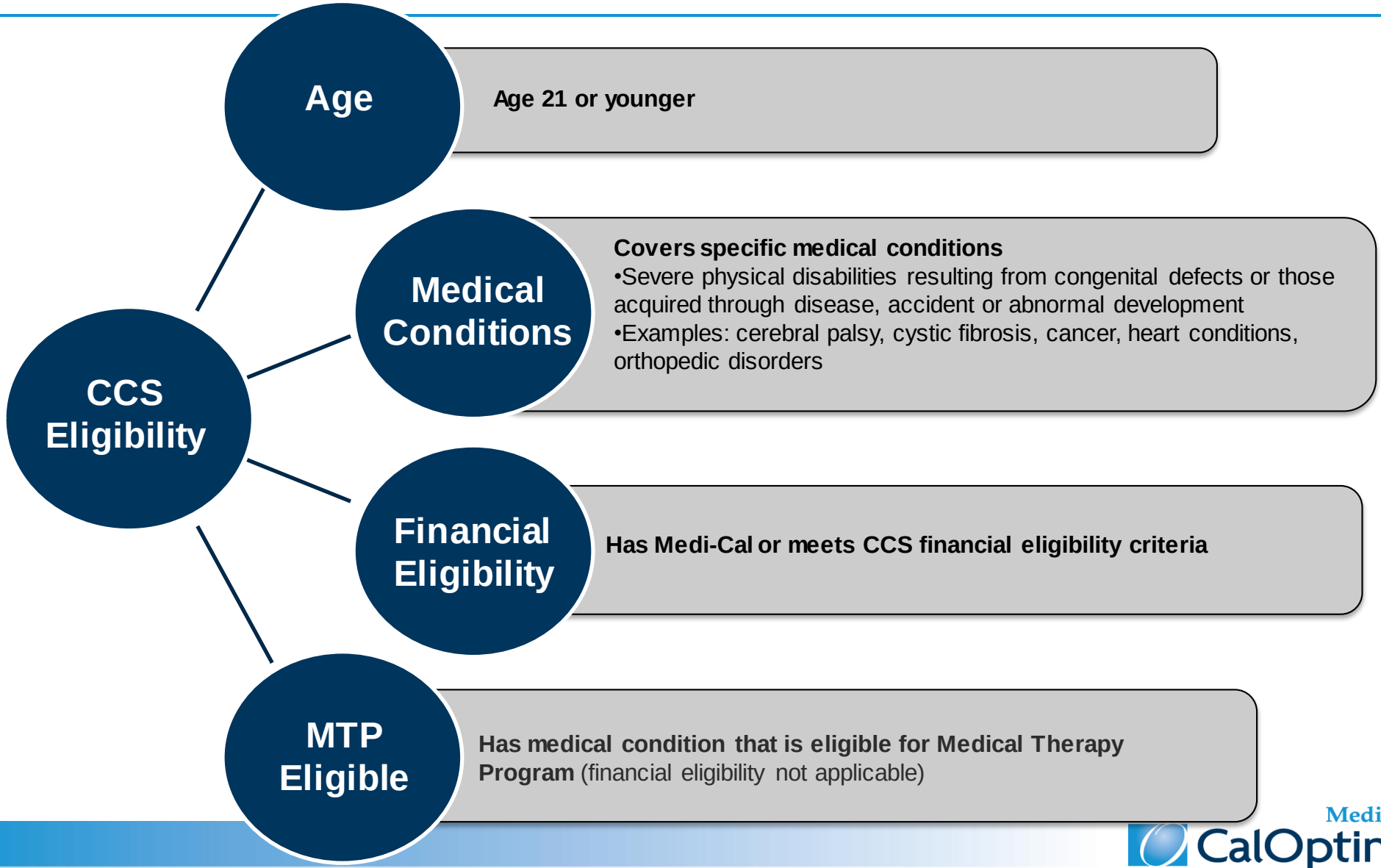
Candice Gomez

Executive Director, Program Implementation

CCS Background

- Statewide program providing medical care, case management, PT/OT and financial assistance for children meeting eligibility criteria
- Three organizational levels
  - State: DHCS - overall policy development
  - Regional offices - monitoring counties (facilities and providers) and consulting.
  - Local county offices - case management, service authorization and direct therapy.
- Funding is through county, state and federal money
- W&I Code that prohibits inclusion of CCS services in most Medi-Cal managed care plans expires January, 2017
  - Carved-in in 6 counties (Marin, Napa, San Mateo, Solano, Santa Barbara and Yolo)

Eligibility Criteria



Medi-Cal CalOptima A Public Agency Better. Together.

Member Demographic Overview

Approximately 13,000 children currently enrolled in CCS

~90% are CalOptima members

Age
- 0-5 Years = 23%
- 6-10 Years = 30%
- 11-15 Years = 23%
- 16-20 Years = 24%

Ethnicity
- Hispanic = 63%
- No Response = 11%
- White = 12%
- Asian or Pacific Islander = 3%

Languages
- Spanish = 48%
- English = 44%
- Vietnamese = 4%
- Unknown = 3%

Cities
- Santa Ana = 26%
- Anaheim = 20%
- Garden Grove = 8%
- Orange = 6%
- Fullerton = 4%
- Costa Mesa = 3%
- Westminster = 3%
- Tustin = 3%
- Huntington Beach = 3%
- Buena Park = 3%
- La Habra, Irvine = 2%

Health Network Participation
- 6% are in COD/CCN
- 94% of members are assigned to a HN

Aid Group
- 77% TANF
- 20% SPD
- 2% Foster

Medi-Cal CalOptima A Public Agency Better. Together.

Guiding Principles

CCS Children

Continuity of care

- Members continue seeing the same providers they currently see
- Existing CCS children and families maintain relationships with their current CCS care coordinators

Integration of services

- Members have “one stop” for CCS and non-CCS-related services

Member choice

- Members access a broad and diverse network of providers that covers the entire county and beyond when necessary

Timely access

- Children receive timely authorizations and appointments with specialists

CCS Providers

Broad participation

- All existing CCS-paneled providers participate in the new Whole-Child Model

Administrative simplification

- Fewer agencies and policies means less fragmentation

Stable payments

- Providers receive 140 percent for CCS specialty care

mmunity

Thoughtful approach

- CalOptima shows careful consideration and ample planning to minimize disruption of any future transition in CCS community

Collaboration

- Families, providers, consumer advocates, CCS program staff and others work together at local stakeholder meetings

Medi-Cal CalOptima A Public Agency Better. Together.

Whole Child Model Proposal

- State proposes transitioning the fee-for-service CCS program into managed care, under Whole-Child Model:
  - Plan will become responsible for
    - Case management, care coordination, provider referral and service authorization will transition to plan
    - Financial risk for Medi-Cal members
  - County will remain responsible for
    - Eligibility determination
    - Medical Therapy Program
    - Administrative and financial responsibility for non-Medi-Cal children
- State will conduct comprehensive review
  - DHCS will assess CalOptima's readiness using same standards as apply to Knox Keene plans

Stakeholder Engagement

- Coordination with HCA
  - Weekly discussions with HCA
  - Focus = information sharing, delivery model ideation, and stakeholder engagement planning

- External stakeholder meetings
  - Kick-off March 25, 2016
  - Planning on periodic provider and CBO stakeholder meetings, as well as MAC, PAC, and Board updates

California Children's Services (CCS) Whole-Child Model

June 2016

No sooner than July 2017, the Department of Health Care Services (DHCS) will start a new program. It will be called the Whole-Child Model. It is for CCS children in certain counties who get CCS and Medi-Cal services.

What is the Whole-Child Model?

The Whole-Child Model is a new way for children with CCS to get care. This model lets CCS children get care from their Medi-Cal managed care health plan (health plan) instead of their county CCS Program. This helps children get all of their care through one system. CCS children already get many non-CCS services through their health plan. This new model will have children get all covered services just from their Medi-Cal health plan and not from both CCS and their Medi-Cal health plan. This means they will get primary and specialty services, hospital visits, some mental health services, and some extra services. CCS children will get the same type of care they now get from providers they do today. CCS children will get the care they need under one system. This will prevent confusion about where they get care, their care will be managed better, and they will have better health results.

What are the benefits of the Whole-Child Model?

- Families can get most of their services and care from one source (their health plan). This will make care easier to get. There will also be better health results for CCS children.
- The services CCS children get now with CCS will not change. They will have the same type of doctor and services with their health plan as they do from their local CCS program.
- It will be easier for CCS children to move out of CCS when they turn 21. This is because they are already getting their services from their health plan and they won't have to change.
- To make sure CCS children get the best care. This is done by making sure the health plans are doing their job well.

Which health plans and counties will the Whole-Child Model be in?

Health Plans	Counties
Partnership HealthPlan	Del Norte, Humboldt, Lake, Lassen, Mendocino, Marin, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
CalOptima	Orange
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz

Will CCS services change in counties that are not part of the Whole-Child Model?

- No. CCS services will stay the same in counties not in the Whole-Child Model.

Will there be changes to the Medical Therapy Program (MTP)?

- No. The county will still be in charge of MTP.

What will the Whole-Child Model offer to my child? Will my child still be able to see their doctor(s)?

- **Able to see the same doctor(s)** – Yes, if a CCS child has a doctor in the health plan's network, your child can still see that doctor. If the doctor is not in the health plan network, your child can still see that doctor for up to 12 months. As long as:
  - The health plan and doctor agree on a payment rate;
  - The health plan does not have concerns with the doctor's quality of care;
  - The doctor shares your child's treatment information with the health plan; and
  - The provider is approved by CCS.

  If your child can't see their doctor anymore, your child will get to see a doctor with the same skills. Your child's services will not change during this time, unless there is a change in your child's health.

- **All of your child's care will be managed together** – Health plans will have a person work with your child's programs and providers. They will make sure your child will get all the services they need. This includes primary and specialty care, inpatient/outpatient care, and mental/behavioral health services.

- **Access to services** - Services will be in the language you speak. Services must be in places that meet your child's needs.

What if I am not happy with the care my child gets with the Whole-Child Model?

- You can file a complaint with your health plan. You can also file a State Fair Hearing. This is where a judge will make a decision about your complaint.

Where can I get more information on the CCS Program changes?

Go to the CCS Advisory Group webpage at: http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

Where can I get more information about the CCS Program?

Go to the CCS webpage at: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

For concerns about CCS, please call (800) 970-8450 or email CCSRedesign@dhcs.ca.gov.

California Children's Services Program (CCS)
Whole-Child Model
Frequently Asked Questions

June 22, 2016

The below frequently asked questions (FAQs) provide information about the Department of Health Care Services' (DHCS) "Whole-Child Model." The Whole-Child Model is an organized delivery system that will provide comprehensive, coordinated services for children and youth with special health care needs through enhanced partnerships with Medi-Cal managed care health plans (health plans). The Whole-Child Model will be implemented no sooner than July 2017. Please note that the Medical Therapy Program (MTP) will continue to be administered by the counties under the Whole-Child Model.

A. General Whole-Child Model Questions

1. What is the Whole-Child Model? Why is DHCS implementing it?

Answer: Children with CCS-eligible conditions today are enrolled in both the CCS fee-for-service (FFS) and managed care delivery systems. As such, they receive their services in two (or more) separate systems that do not always coordinate and communicate effectively. This can result in additional complexity for families to navigate access to care among other care coordination issues. Under the Whole-Child Model, DHCS intends to eliminate this bifurcated system, strengthening overall care coordination for the beneficiary and their family resulting in better overall health outcomes and better beneficiary access to care. Health plans will coordinate the beneficiary's full scope of health care needs, inclusive of primary preventative care, specialty health, mental health, education, and training rather than multiple entities coordinating these efforts separately. Beneficiaries and their families in a single integrated system of care will benefit from a single point of care coordination.

2. **Which health plans and counties will be in the Whole-Child Model?**

   Answer: The Whole-Child Model is proposed to be implemented in the health plans /counties shown below.

Health Plan	Counties
CalOptima	Orange
Central California Alliance for Health	Merced, Monterey, Santa Cruz
CenCal Health	San Luis Obispo, Santa Barbara
Health Plan of San Mateo	San Mateo
Partnership HealthPlan	Del Norte, Humboldt, Lake, Lassen, Mendocino, Marin, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo

3. **What will happen in counties where the Whole-Child Model is not implemented?**

   Answer: There are no further counties contemplated for the Whole-Child Model at this time. Thus, there will be no change to the services that a CCS-eligible child gets in counties that do not have the Whole-Child Model.

4. **Who can get Whole-Child Model services?**

   Answer: CCS-eligible beneficiaries who are on full scope Medi-Cal and live in Whole-Child Model counties (See A.2 above) will get coordinated services. The services in these counties and health plans will be phased in over time.

5. **Is the CCS Program going away? Who will be responsible for the CCS Program in Whole-Child Model counties?**

   Answer: No. The CCS Program is not going away. However, the way children and families get services and how their care is managed will change. As we put program improvements in place, CCS children and their families will not have to change their current services. Beneficiaries will become eligible in the same way as always, through the Local and State CCS Programs. Health plans will manage the care overall in the Whole-Child Model counties. They will also take care of approving the services.

6. **Who will provide CCS services in the Whole-Child Model?**

   Answer: Health plans will coordinate and approve all care for beneficiaries. Beneficiaries will be able to get their health care through providers who are part of the plan's network. These providers must be CCS providers with special skills (paneled

providers). If a child needs to see a specialist that is not in the plan's network or is located in a different part of the state, the plan will coordinate and approve those services as well.

7. Will beneficiaries in the Whole-Child Model keep the same benefits?

Answer: Yes. Children will have the same covered benefits, including primary, specialty, pharmacy, ancillary, and other services, as long as the services are still medically necessary and prescribed by the child's treating physician. The arrangement and coordination of the care will be strengthened under Whole-Child Model. Instead of arranging for care through multiple systems for authorization of services and appealing denials between systems, the model will now allow CCS children to get care through one system. This model will make it easier for CCS children to get the care they need and will result in better health outcomes.

8. Will the local county CCS Program (case manager) go away if my child is part of the CCS Whole-Child Model?

Answer: No, local county CCS Programs will not go away under the Whole-Child Model. They will still conduct eligibility services for beneficiaries. They will also continue to be responsible for Medical Therapy Program and a few other services. The main change will be that the health plans will make sure that care is arranged and services are approved so beneficiaries get the care they need.

9. Will beneficiaries get a notice about the transition to the Whole-Child Model?

Answer: Yes. Each child will receive at least two notices before the change to the Whole-Child Model takes place. Health plans will also be required to call each beneficiary up to five times or until they are reached. All notices and call scripts will be reviewed and will be shared for public comment.

10. Can beneficiaries still see their primary care and specialist providers?

Answer: Yes. DHCS will require that each child's primary care and specialist providers be involved with his or her care (continuity of care) for up to 12 months following the transition to Whole Child Model. Continuity of care will be automatic, meaning that beneficiaries will not have to request it; health plans will automatically engage with beneficiary providers prior to the transition occurring to enter into agreements. DHCS will monitor health plans closely to ensure they are providing continuity of care. The Department will review continuity of care policies and procedures prior to the transition occurring and collect monthly data until no longer needed to determine health plan compliance. It is important to note that health plans can agree to extend continuity of care beyond the 12 month period, however, if this is not possible, a warm handoff to a new CCS provider will occur ensuring no gaps in care occur.

11. Will CCS providers still need to be paneled by the DHCS CCS Program?

Answer: Yes, providers still need to be paneled by the CCS Program. DHCS has no plans to change the way in which a pediatric provider becomes a CCS Program paneled provider.

12. Will the CCS Program standards for providers that are in place now be in the Whole-Child Model?

Answer: Yes. The CCS Program provider standards that are in place now will still be a requirement. CCS Program standards are available at http://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx.

13. How will the CCS State-only children (which include children with other health coverage or undocumented children) who are not Medi-Cal beneficiaries get CCS services under the CCS Whole-Child Model?

Answer: The CCS State-only children with other health coverage will continue to receive services the way they do today. The CCS services for children who do not have Medi-Cal will still be on a FFS basis.

Effective May 2016, children under 19 years of age without satisfactory immigration status became eligible for full-scope Medi-Cal benefits. To the extent that these undocumented children also have a CCS-eligible condition, they will be enrolled in the Whole-Child Model counties so that all their coverage will be coordinated as described above.

B. Managed Care Questions

1. What are the benefits of being in managed care?

Answer: There are many benefits of being in managed care. Here are a few examples:

Care is available:

- ✓ Primary Care Physician (PCP) assignment. Health plans need to make sure beneficiaries always have a PCP. Beneficiaries and their families may either choose a PCP or have one chosen for them by the health plan. Beneficiaries and their families can change their doctor to another in-network doctor at any time.
- ✓ Timely access to appointments. PCPs and specialists must offer appointments within certain time requirements.
- ✓ Time and distance standards. PCPs must be located within 30 minutes or 10 miles of where a beneficiary lives. But, a beneficiary or their family can have a different PCP that is farther away if they want.

- ✓ Out of network access. Health plans must make sure beneficiaries have access to all medically necessary services. This means that beneficiaries can get services out of the network if they cannot find them in the health plan's network.

Health plans must give beneficiaries and their families resources for their care. This includes:

- ✓ Provider lists. Health plans must have a list of providers in print and electronic forms. These lists will help beneficiaries and their families sees the types of providers that are in the health plan's network and where their offices/clinics are.
- ✓ Member services. Health plans must have a Member Services Center. This will help beneficiaries and their families when they have questions including how to get find a doctor and access care.
- ✓ Interpreter services. Translators are available 24 hours a day, seven days a week.
- ✓ Care coordination. Health plans must have a care coordination team available to ensure access across an array of services and coordinate referrals and authorizations.

2. How will DHCS make sure that health plans provide access to CCS providers in their network?

Answer: DHCS will require health plans to contract with CCS paneled providers and make them available to beneficiaries in their networks ensuring timely access to care. DHCS reviews health plan networks prior to implementation to ensure they are adequate and continues to monitor network adequacy following implementation based upon population size and service needs.

3. How will DHCS make sure health plans are following the requirements of the Whole-Child Model?

Answer: DHCS utilizes multiple approaches when monitoring health plans. Initially DHCS monitors transitions during the implementation period and up to two years after a transition starts. DHCS collects and analyzes data for the transitioning population to ensure appropriate access to services is being provided in a timely manner. DHCS also utilized the below monitoring tools in addition to others:

- ✓ Encounter data
- ✓ Provider networks
  - o Provider certification
  - o Number of providers in a given area
  - o Time and distance
  - o Timely access
- ✓ Grievances and appeals and State Fair Hearings
- ✓ Annual audits
- ✓ Continuity of care
- ✓ Utilization data

- ✓ Health plan call center data
- ✓ DHCS Ombudsman call center data

DHCS has a formal process for monitoring and providing health plans with technical assistance, imposing corrective action plans, and applying penalties, as appropriate. DHCS will develop a specialized monitoring tool for the Whole-Child Model.

C. Beneficiary Protections

1. **What happens if a beneficiary is not happy with a provider or does not like the services they get from the health plan?**

   Answer: If a beneficiary is not happy with their services, they should first ask the health plan to help them resolve their concern. Beneficiaries and their families can contact the health plan's Member Services department These Member services departments are specifically designed to help beneficiaries with all kinds of issues ranging from answering questions to finding a provider for assistance. Beneficiaries can also file a complaint directly with the health plan which is a more formal process to express a concern. They may also request a State Fair Hearing. A State Fair Hearing is a process where beneficiaries can complain directly to the State of California and an Administrative Law Judge will review the complaint.

D. Medical Therapy Program (MTP)

1. **Will MTP change because of the CCS Whole-Child Model? If counties continue to run the MTP, how will health plans be involved?**

   Answer: Counties will continue to administer MTP. Health plans and counties will be required to work together and coordinate services for beneficiaries receiving services from both MTP and the health plan.

E. Stakeholder Engagement

1. **How will DHCS seek input from stakeholders on the Whole-Child Model?**

   Answer: DHCS will send out various documents for comment throughout and following the Whole-Child Model implementation period. DHCS will carefully consider all input received as the Department works to finalize decisions regarding implementation. In addition, DHCS established the CCS Advisory Group as an entity that can provide input into CCS overall which includes the Whole-Child Model. The Advisory Group consists of a broad range of individuals ranging from beneficiaries and/or their family members, providers, government entities, health plans, and other. Advisory Group meetings are held quarterly and are open to the public.

F. Where to Find More Information

1. Where can CCS beneficiaries and their families go if they have questions about the Whole-Child Model?

Answer: Go to the DHCS CCS Advisory Group webpage at http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

For questions or comments, please send an email to CCSRedesign@dhcs.ca.gov

CCS beneficiaries and their families can also call the CCS Program at **1-800-970-8450**, Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free.

Fiscal Year (FY) 2016-17 State Budget Update
CalOptima Member Advisory Committee (MAC) Meeting
July 14, 2016

California Fiscal Year (FY) 2016–17 State Budget

Senate Bill (SB) 826, the legislative vehicle for enacting the FY 2016-17 budget, was signed into law by the Governor on June 27, 2016. The budget bill preserves the spending priorities outlined in the Governor's May Revision. The table below compares FY 16-17 Overall, General Fund and Medi-Cal spending to FY 15-16 spending.

	Overall	General Fund	Medi-Cal
FY 16-17	$170.8 billion	$122.5 billion	$90.1 billion ($17.6 billion GF)
FY 15-16	$167.5 billion	$115.3 billion	$90.9 billion ($18 billion GF)
% Change	1.9% increase	6.2% increase	0.8% decrease

The outlook for Medi-Cal program spending remains positive under the enacted budget, with overall spending at $90.1 billion and the General Fund obligation to Medi-Cal at $17.6 billion. The FY 16-17 Medi-Cal budget includes funding from California's Section 1115 waiver and the Managed Care Organization (MCO) tax. Major issues that are pertinent to CalOptima are noted below.

Medi-Cal 2020 Waiver Funding

The budget includes $2.2 billion in federal funds connected to California's Section 1115 renewal waiver, called "Medi-Cal 2020." The federal funds included in the budget will support Medi-Cal 2020's major programs, including the Whole Person Care (WPC) pilots (details highlighted below), the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, the Global Payment Program (GPP) and the Dental Transformation Initiative (DTI).

WPC Pilot Programs

WPC is focused on improving the care provided for persons who frequently utilize multiple systems of social, behavioral and health care in a specific geographic area. The program emphasizes developing the infrastructure of coordination and cooperation among entities that deliver services to the affected population. Through this collaborative approach the Department of Health Care Services (DHCS) hopes to identify target populations of chronic utilizers, facilitate data-sharing between systems, create the infrastructure for real-time care coordination and evaluate progress among individuals in the target population.

WPC in Orange County

The Orange County Health Care Agency (HCA) is the lead entity for Orange County's WPC pilot and its application was recently approved for submission by the Orange County Board of

Supervisors. HCA submitted the application to DHCS on June 30. After reviewing applications, the state will select and notify participating counties by October 24, 2016. CalOptima is a required WPC participant, as the County's Medi-Cal managed care plan, and HCA drafted its WPC application with the agency's input and participation. The Orange County WPC pilot will focus on Medi-Cal beneficiaries, with an emphasis on individuals that are seriously mentally ill, who are or may be homeless or at risk of homelessness.

MCO Tax

The budget reflects General Fund savings of $1.1 billion related to the passage and approval of the MCO tax. The MCO tax is a health care financing program used by California to access federal matching dollars. The new MCO tax takes effect in July and runs for three years through June 2019. Among other significant impacts, MCO tax revenue will facilitate the continuation of the Coordinated Care Initiative (CCI), contingent on improvements in enrollment, the restoration of In-Home Supportive Services (IHSS) service hours and the allocation of increased funding for programs serving people with developmental disabilities.

CalOptima will incur an estimated MCO tax liability of approximately $110 million for FY 2016-17. However, enhanced capitation rates related to additional federal dollars drawn down by the tax will make the net financial impact on CalOptima negligible ($2,505 for FY 2016-2017 according to a Local Health Plans of California projection).

With the approval of the MCO tax, the budget authorizes CCI (CalOptima's OneCare Connect program) through January 1, 2018. However, the Administration continues to share its concerns regarding participation rates in the program. If participation rates in the program are not improved by January 2017, CCI could cease operating effective January 1, 2018. CalOptima will continue working with state and federal regulators as well as health care stakeholders to identify strategies to increase enrollment in OneCare Connect.

The budget also includes a $265.8 million General Fund allocation to restore the 7 percent reduction to IHSS service hours and $287 million General Fund for programs that serve individuals with developmental disabilities. As currently interpreted by the California Department of Finance, the funding for programs that serve individuals with developmental disabilities will be considered a continuous appropriation and will not be tied to the sunset date of the MCO tax (July 1, 2019).

Medi-Cal Expansion

The budget assumes that the Medi-Cal population will grow to 14.1 million in 16–17, which represents more than a third of the state's population. For the first three years of Medi-Cal expansion through the Affordable Care Act (calendar years 2014, 2015 and 2016), the federal government covered 100 percent of the costs. Beginning in January 2017 (the halfway point of FY 16–17), the state will assume a 5 percent share of the costs for this population. The budget includes an expenditure of $819.5 million General Fund for the state's share of Medi-Cal expansion costs in 2016–17.

Medi-Cal for All Children

Under Senate Bill 75, children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements. This population began enrollment with CalOptima on June 1, 2016, with benefits retroactive to May

1. Approximately 9,800 children in Orange County who are currently enrolled in limited scope Medi-Cal are in the process of being transitioned into full-scope coverage. On an annual basis, an estimated 15,000 children in Orange County are expected to join CalOptima as newly eligible Medi-Cal members as part of this coverage expansion. The budget estimates that 185,000 children statewide will receive full-scope benefits during the first year of this transition and includes $188.2 million General Fund for the implementation of this transition.

Acupuncture as Covered Benefit

The budget allocates $3.7 million General Fund to restore acupuncture as a covered Medi-Cal benefit beginning July 1, 2016. The acupuncture benefit was eliminated in 2009 as part of the state's response to the 2008 recession. CalOptima is awaiting guidance from DHCS on how the restoration of this benefit will be implemented.

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

Though the budget bill has been signed into law, a number of "trailer bills" are still awaiting passage. A trailer bill is the legislative vehicle that helps enact the state budget. Generally, each major area of budget appropriation—such as transportation or education—has a separate trailer bill. Assembly Bill (AB) 1605 is one of the omnibus health trailer bills in the California legislature and it contains the "PACE Modernization Act" language. It is due to be heard by the full Senate on August 1.

The PACE Modernization portion of the health trailer bill will enact a number of noteworthy changes, including an adjustment of the PACE reimbursement structure. Currently, DHCS calculates PACE reimbursement rates by determining how much it would cost to provide a PACE member's full range of services—occupational therapy, dental care, prescription drugs, etc.—if these services were provided on a fee-for-service (FFS) basis. DHCS then reimburses the PACE program for 95 percent of the cost of providing these services. Under the current rate calculation methodology, CalOptima is reimbursed at the second lowest rate of all PACE programs in the state. FFS rates vary by geographic area and it is possible that the lower reimbursement rates in Southern California are related to the prevalence of the more cost-efficient managed care model in the region. This effect may be exacerbated in Orange County since Medi-Cal is only available in the county through CalOptima's managed care plan.

The PACE Modernization Act would introduce a new process for calculating PACE reimbursement rates that is more likely to account for geographic rate disparity. First, reimbursement rates will be calculated taking into account *actual cost* data for each PACE center. Second, the rates will then be analyzed by a workgroup for actuarial soundness. Third, DHCS will be empowered to adjust the rate further to mitigate any remaining geographic rate disparity. It is anticipated that the new rate setting methodology will have a positive impact on reimbursement rates for CalOptima PACE.

Next Steps

CalOptima will closely follow the status of the remaining trailer bills and provide updates regarding issues that have a significant impact on the agency.

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. As one of Orange County's largest health insurers, we provide coverage through four major programs: Medi-Cal, OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and PACE (Program of All-Inclusive Care for the Elderly).

If you have any questions regarding the above information, please contact:

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(657) 900-1296; smcreynolds@caloptima.org

Member Advisory Committee
FY 2016-2017 Meeting Schedule

July
Thursday, July 14, 2016

September
Thursday, September 8, 2016

November
Thursday, November 10, 2016

January
Thursday, January 12, 2017

March
Thursday, March 9, 2017

May
Thursday, May 11, 2017

Regular Meeting Location and Time

CalOptima
505 City Parkway West, 1st Floor
Orange, CA 92868
Conference Room 109-N
2:30 p.m. – 5:00 p.m.
www.caloptima.org

All meetings are open to the public. Interested parties are encouraged to attend.

MEMBER ADVISORY COMMITTEE VOTING MEMBERS
FY 2016–2017

CONSTITUENCY REPRESENTED/TERM	MAC MEMBER NAME and ADDRESS	CONTACT INFORMATION
SENIORS Term: 7/1/15–6/30/17 Member since 2012	**Chair** **Mallory Vega** Executive Director Acacia Adult Day Services 11391 Acacia Parkway Garden Grove, CA 92840	**Work Phone:** 714-530-1566 **Cell Phone:** 714-883-7724 **Fax:** 714-530-1592 **Email:** mvega@acacia-services.org
ADULT BENEFICIARIES Term: 7/1/15–6/30/17 Member since 2013	**Sandra Finestone** Executive Director Hope Wellness Center 17952 Sky Park Circle, Ste. J Irvine, CA 92614	**Work Phone:** 949-261-6020 **Cell Phone:** 714-401-6495 **Fax:** 949-261-2001 **Email:** sandyfinestone@aol.com
CHILDREN Term: 7/1/16–6/30/18 Member since 2014	**Christina Sepulveda** Vice President, Programs & Services Boys and Girls Clubs of Garden Grove 10540 Chapman Ave. Garden Grove, CA 92840	**Work Phone:** 714-530-0430 ext. 1927 **Fax:** 714-530-0431 **Email:** csepulveda@bgcgg.org
CONSUMER Term: 7/1/16–6/30/18 Member since 2012	**Lisa Workman** CalOptima Consumer 505 City Parkway West Orange, CA 92868	**Work Phone:** 714-447-3301 **Cell Phone:** 714-944-2520 **Fax:** 714-447-3302 **Email:** lisa.workman63@gmail.com
FOSTER CHILDREN Term: 7/1/16–6/30/18 Member since 2014	**Gene Howard** Executive Director OC Alliance for Children and Families 18712 Saginaw Dr. Irvine, CA 92603	**Work Phone:** 714-310-0521 **Email:** ghoward@orangecountyalliance.org
HEALTH CARE AGENCY Standing Seat Member since 2013	**Donna Grubaugh** Chief of Health Policy, Research & Communications Orange County Health Care Agency 405 W. Fifth St., Ste. 438 Santa Ana, CA 92701	**Work Phone:** 714-834-2195 **Cell Phone:** 714-334-6165 **Fax:** 714-834-7644 **Email:** dgrubaugh@ochca.com

CONSTITUENCY REPRESENTED/TERM	MAC MEMBER NAME and ADDRESS	CONTACT INFORMATION
FAMILY SUPPORT Term: 7/1/15–6/30/17 Member since 2015	**Victoria Hersey** Advocate for children and adults with disabilities P.O. Box 10189 Newport Beach, CA 92658	**Work Phone:** 949-675-9014 **Fax:** 949-675-9494 **Email:** vhersey@earthlink.net
LONG-TERM CARE Term: 7/1/16–6/30/18 Member since 2012	**Velma Shivers, RN** Ombudsman Field Services Manager Council on Aging – Orange County 2 Executive Circle, Ste. 175 Irvine, CA 92614	**Work Phone:** 714-479-0107 **Cell Phone:** 323-376-5700 **Fax:** 714-479-0234 **Email:** vshivers@coaoc.org
MEDI-CAL BENEFICIARIES Term: 7/1/15–6/30/17 Member since 2013	**Patty Mouton** Vice President, Outreach & Advocacy Alzheimer's Orange County 2515 McCabe Way Irvine, CA 92614	**Work Phone:** 949-757-3713 **Cell Phone:** 714-349-5517 **Email:** patty.mouton@alzoc.org
MEDICALLY INDIGENT PERSONS Term: 7/1/16–6/30/18 Member since 2004	**Sally Molnar** Public Policy Chair Susan G. Komen for the Cure 412 Vista Roma Newport Beach, CA 92660	**Cell Phone:** 714-742-9345 **Email:** salortho@aol.com
PERSONS WITH DISABILITIES Term: 7/1/15–6/30/17 Member since 2010	**Suzanne Butler** Insurance and Benefits Specialist Regional Center of Orange County P.O. Box 22010 Santa Ana, CA 92702	**Work Phone:** 714-796-5253 **Fax:** 714-796-5200 **Email:** sbutler@rcocdd.com
PERSONS WITH MENTAL ILLNESS Term: 7/1/16–6/30/18 Member since 2014	**Sr. Mary Therese Sweeney** Director St. Joseph Health 3345 Michelson Drive Irvine, CA 92612	**Work Phone:** 949-381-4733 **Fax:** 949-381-4979 **Email:** Sr.MaryTherese.Sweeney@stjoe.org
PERSONS WITH SPECIAL NEEDS Term: 7/1/16–6/30/18 Member since 2016	**Christine Tolbert** Community Program Specialist II State Council on Developmental Disabilities 2000 E. 4th St., Ste. 115 Santa Ana, CA 92705	**Work Phone:** 714-558-4404 **Fax:** 714-558-4704 **Email:** christine.tolbert@scdd.ca.gov

CONSTITUENCY REPRESENTED/TERM	MAC MEMBER NAME and ADDRESS	CONTACT INFORMATION
RECIPIENTS OF CalWORKs	**Vacant**	
SOCIAL SERVICES AGENCY Standing Seat Member since 2014	**Connie Gonzalez** Administrative Manager I Social Services Agency 500 N. State College Blvd. Orange, CA 92868	**Work Phone:** 714-541-7891 **Fax:** 714-245-6188 **Email:** connie.gonzalez@ssa.ocgov.com