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

THURSDAY, SEPTEMBER 13, 2018
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 July 12, 2018 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee.

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 Member Advisory Committee. 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
A. Consider CalOptima Delivery System Overview and Related Recommendations
B. Consider Recommendations Related to Changes to the Member Auto-Assignment Limits for the CalOptima Community Network

VI. CEO AND MANAGEMENT REPORTS

A. Chief Executive Officer (CEO) Update
B. Chief Medical Officer (CMO) Update
C. Chief Operating Officer (COO) Update
D. Federal and State Legislative Update
E. Network Operations Update

VII. INFORMATION ITEMS

A. Member Advisory Committee Member Updates
B. Health Homes Program Update
C. Intergovernmental Transfer (IGT) Funds 5, 6 and 7 Update
D. Annual Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Update
E. Cultural & Linguistics Overview

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

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MINUTES

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

July 12, 2018

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on July 12, 2018, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Sally Molnar called the meeting to order at 2:36 p.m., and Chair Molnar led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler; Connie Gonzalez; Jaime Muñoz; Christine Tolbert; Diana Cruz-Toro; Luisa Santa; Mallory Vega

Members Absent: Elizabeth Anderson; Sandy Finestone; Donna Grubaugh; Ilia Rolon; Sr. Mary Therese Sweeney

Others Present: Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, MD, Medical Director; Sesha Mudunuri, Executive Director, Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Betsy Ha, Executive Director, Quality Analytics, Ana Aranda, Director, Grievance and Appeals, Arif Shaikh, Director, Government Affairs, Marsha Choo, Manager, QI Initiatives, Belinda Abeyta, Director, Customer Service; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the May 10, 2018, Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT

There were no requests for Public Comment.

REPORTS

Consider Approval of Updating Fiscal Year (FY) 2018-2019 MAC Goals & Objectives

Member Patty Mouton reported on the MAC Goals & Objectives Ad Hoc Subcommittee composed of MAC members Sally Molnar, Ilia Rolon and Patty Mouton. At the May 10, 2018 MAC meeting, Member Tolbert requested clarification on Partnership and Engagement section of MAC's Goals & Objectives as it relates to measurable outcomes. The MAC Goal & Objectives Ad Hoc Subcommittee reconvened on June 7, 2018 and June 21, 2018 to discuss adding measurable

outcomes. The ad hoc recommended updating the FY2018-2019 Goals & Objectives item III, Partnership and Engagement, to include the following: Convene a MAC Ad Hoc Subcommittee to partner with CalOptima staff to review the Member Health Needs Assessment (MHNA) and provide input and recommendations that will assist in addressing the MHNA findings.

Action: ***On motion of Committee Member Suzanne Butler, seconded and carried, the MAC approved the Updated Fiscal Year (FY) MAC FY 2018-2019 Goals & Objectives. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

Consider Recommendation of MAC Candidate

Member Vega reported on the Nominations Ad Hoc Subcommittee, composed of MAC members Suzanne Butler, Sandy Finestone and Mallory Vega, which met on June 5, 2018 to evaluate the application for the vacant Consumer representative seat for FY 2018-2019. The Nominations Ad Hoc recommended Jacque Ruddy for the Consumer representative seat for a term ending June 30, 2020. The recommendation will be presented to the Board of Directors on June 7, 2018 for consideration.

Action: ***On motion of Member Patty Mouton, seconded and carried, the MAC recommended Board of Directors' consider the appointment of Jacque Ruddy to the Consumer Representative seat for a term ending June 30, 2020. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

Consider Recommendation of Whole-Child Model Family Advisory Committee (WCM FAC) Slate of Candidates

Member Tolbert reported that the Whole-Child Model Family Advisory Committee (WCM FAC) Ad Hoc Subcommittee, composed of MAC members Connie Gonzalez, Jaime Munoz and Christine Tolbert, reconvened on July 11, 2018 to review the proposed slate of candidates for four voting seats representing the Community representatives that will establish the new WCM FAC. After reviewing the applications and selecting a candidate for each seat, the Nominations Ad Hoc recommended the following Community Representative appointments: Michael Arnot and Diane Key for a two-year term ending June 30, 2020; and Pamela Austin and Sandra Cortez-Schultz to serve for a one-year term ending June 30, 2019. The recommended candidates will be presented to the Board of Directors on June 7, 2018 for consideration.

Action: ***On motion of Member Mallory Vega, seconded and carried, MAC recommended Board of Directors' consider the appointment of Michael Arnot, Pamela Austin, Sandra Cortez-Schultz and Diane Key as the WCM FAC Community Representatives as presented. (Motion carried 9-0; Members Anderson, Finestone, Grubaugh, Rolon, and Sweeney absent)***

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CEO AND MANAGEMENT REPORTS

Chief Medical Officer Update

Dr. Emily Fonda, Medical Director, presented an overview of the Whole-Child Model (WCM) program that will be effective January 1, 2019, within 21 counties and five health plans. The Whole-Child Model will incorporate California Children's Services (CCS) into Medi-Cal Managed Care. Next steps are to continue meeting with Orange County Health Care Agencies and Health Networks on transition, developing WCM policies, internal workflows, contracting with CCS panel physicians, establishing two advisory groups, and holding stake holder events within the community.

Chief Operating Officer (COO) Update

Ladan Khamseh, COO, provided an update on the transition of members with a non-autism spectrum disorder receiving behavioral health services at the Regional Center of Orange County (RCOC) and are scheduled to transition to CalOptima beginning July 1, 2018. CalOptima will be completing the transition in stages with the first stage occurring July 1, 2018, second stage will be August 1, 2018, and the final transition to occur October 1, 2018. Impacted members will receive 60 and 30-day notices advising them of the transition and to call CalOptima with any questions or concerns.

Federal and State Legislative Update

Arif Shaikh, Director, Public Affairs, provided an update on the state budget.
Not all legislative items in the proposed budget were approved, which directly impacts CalOptima and our membership, including approximately $26 million to streamline Medi-Cal eligibility for the Women's Infants and Children (WIC) program; the expansion of Medi-Cal for low-income seniors; alignment with federal policy for transitional Medi-Cal under the CalWorks program and Welfare to Work Program; and $250 million to extend Medi-Cal to the undocumented population. Mr. Shaikh also reported on trailer bills that CalOptima is following this year, including Proposition 56 supplemental payments from the tobacco tax initiative, and trailer bill 340b related to drug pricing and duplicate discounts.

INFORMATION ITEMS

MAC Member Updates

Chair Molnar introduced two new Committee members: Children's Representative Luisa Santa, and Diana Cruz-Toro, Recipients of CalWORKS Representative. Chair Molnar announced that the MAC and Provider Advisory Committee (PAC) will hold a joint meeting on November 8, 2018 and requested volunteers to serve on an ad hoc to work with the PAC to develop the joint meeting agenda. Vice Chair Mouton and Member Tolbert volunteered to serve on this ad hoc with Chair Molnar. Additionally, it was announced that Vice Chair Mouton will join Chair Molnar on the Goals and Objectives Ad Hoc to review the medical health needs assessments.

Chair Molnar requested volunteers to present at the September 13, 2018 MAC meeting. Member Santa volunteered to present on MOMS Orange County.

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Update on Palliative Care

Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on Senate Bill 1004, which requires the DHCS to establish standards and provide technical assistance to ensure delivery of palliative care services by Managed Care Plans for members of any age. In response to the Senate Bill, the DHCS released an All-Plan letter updating palliative care guidelines that were effective January 1, 2018 and identified eligibility criteria for this initiative which focuses on four general categories: cancer, chronic obstructive pulmonary disease, congestive heart failure and liver disease. Palliative care will be coordinated by the health networks with oversight by CalOptima. Next steps include community education events, provider education, and additional staff training.

Member Mouton requested additional information on the number of referrals to palliative care compared to the number of referrals to hospice and the length of time a member receives palliative care services.

Access to Care Overview

Marsha Choo, Manager, Quality Improvement Initiatives, provided an overview on Access to Care. CalOptima's Access and Availability subcommittee reviews network adequacy and timely access survey. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) reviews out of network requests, and grievance and appeals. DHCS requires a network adequacy certification, and CalOptima has passed the required certification. Next steps include: educating providers on timely access standards; continuing to recruit and contract with in-demand specialists, particularly in South County; provider coaching; and requesting correction action plans from our contracted health networks when performance is below the required standards.

Member Tolbert requested discussion at a future MAC meeting regarding intellectual disabilities in autism.

Grievance and Appeals Process

Ana Aranda, Interim Director, Grievance and Appeals, provided an overview on the Grievance and Appeals process. A member can submit a grievance anytime and submit an Appeal up to 60 days from the Notice of Action. An acknowledgement letter is mailed to the member or authorized representative within five calendar days indicating that CalOptima is in receipt of their grievance or appeal. The Grievance Resolution Specialist will contact the member if clarification or additional information is needed, assists the member with any immediate needs, and works with internal departments, health networks, and providers to resolve the member's concerns. When a member needs timely access to care, CalOptima coordinates services by contacting the provider to arrange an earlier appointment for the member. Alternatively, CalOptima will coordinate changing the provider referral to obtain a timely appointment. Grievance tracking and trending reports are in place to address areas of improvement, and information is shared with internal and external stakeholders for further action.

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ADJOURNMENT

Chair Molnar announced that the next MAC meeting is Thursday, September 13, 2018 at 2:30 p.m.

Hearing no further business, Chair Molnar adjourned the meeting at 4:14 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: September 13, 2018

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CalOptima Delivery System Review

Member Advisory Committee (MAC) Meeting
September 13, 2018

Greg Hamblin, Chief Financial Officer

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Overview

- Background: Provider Network
- Comparable Health Plans
- Last CalOptima Network RFP
- Delivery System Metrics
  - Medi-Cal Membership by Network
  - Contracted Medi-Cal Providers by Network
  - Contracted Hospitals by Network
- Quality/ HEDIS Metrics
- Financial Metrics
- Health Network Requirements
- Summary/ Considerations

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Background: Provider Network

History of Health Networks – Year First Contracted with CalOptima

1995 (23 years)	2003 (15 years)	2004 (14 years)	2006 (12 years)	2015 (3 years)
• CHOC Health Alliance • Kaiser Permanente • Prospect Medical Group • United Care Medical Network	• Arta Western* • Family Choice Health Network* • Noble*	• Monarch Family Healthcare • Talbert Medical Group	• AMVI Care Health Network • Alta Med Health Services	• OC Advantage**# • Heritage – Regal Medical Group**

* Health networks have been contracted since at least January 1, 2003

** Health networks were added as part of the network expansion related to Medi-Cal Expansion and OneCare Connect (OCC) program implementation

Health network has not been able to meet minimum membership requirement of 5,000 members after three years

Background: Provider Network (cont.)

- CalOptima non-delegated responsibilities (for all members)
  - Grievances and appeals (except Kaiser)
  - Health education (except Kaiser)
  - Long term services & supports (except Kaiser)
  - Managed care plan – Provider screening for Medi-Cal
  - Member and provider communications
  - Model of Care
  - Oversight of health networks and delegates
  - Provider data management/ Provider directory
  - Quality improvement
- Health network delegated key responsibilities
  - Claims
  - Credentialing
  - Provider contracting
  - Utilization management
- CalOptima performs all health network functions for CCN/COD

Comparable Health Plans

- Queried two of the largest Medi-Cal plans in California: LA Care and Inland Empire Health Plan (IEHP)
  - Consistent responses between the two plans
    - Have not performed a request for proposal (RFP) for re-procurement related to core health network providers
    - Any substantial changes to the provider network would be disruptive to existing members
  - Most all provider contracts are evergreen (no annual renewal)
    - Contract amendments are made, as required

Comparable Health Plans (cont.)

	CalOptima	Inland Empire	LA Care
Issuance of RFP	RFP issued for significant increase in MCE population growth and Medicare/ Medi-Cal providers for OCC	Has not issued RFP or re-procurement of core Medi-Cal network	Has not issued RFP or re-procurement of core Medi-Cal network
Medi-Cal Membership (June 2018)	Orange: 756,881	Total: 1,222,350 Riverside: 604,614 San Bernardino: 617,736	Los Angeles: 2,066,390
Delegated Entities	HMO/IPAs: 13	IPAs: 17	IPAs: 28
Global Sub-capitated arrangements (100% full risk)	One health plan: • Kaiser	One health plan: • Kaiser	3 health plans: • Kaiser • Anthem • Care First
Contracted Hospitals	30	30	40
Direct Provider Network (Y/N)	Y	Y	Y
Contract Period	Generally, 1 year period – Renewed on an annual basis	Evergreen (no specific end date) – Rates and other contract changes made as needed through amendments	Evergreen (no specific end date) – Rates and other contract changes made as needed through amendments

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Last CalOptima Network RFP

- March 2013: Released RFP to modify or add health networks
  - Reason for RFP
    - New members: Medi-Cal Expansion expected to increase membership by over 45%
    - Need for Providers: OCC implementation to begin July 2014; need to add providers who serve Medicare members
  - Evaluated medical groups and health plans based on their ability to meet the minimum quality, administrative and financial participation criteria
  - Developed formal scoring criteria to evaluate RFP responses
  - Used Board-approved criteria to select medical groups and health plans
- At the same time, CalOptima explored direct contracting with independent providers through CCN to maintain provider-patient relationships through OCC implementation
  - Any willing and qualified provider
  - Providers had to agree to CalOptima contract terms and requirements in order to contract

Last CalOptima Network RFP (cont.)

- RFP submission and results
  - 17 proposals submitted
    - 5 proposals from existing health networks proposing to change their current contract model (e.g., SRG to full risk HMO)
    - 12 proposals from new health networks

	Total Number
Total number of new health networks assessed	12
Number of health networks that met the RFP minimum requirements	5
Number of health networks that chose not to contract due to readiness review, contract terms, or other business decisions	3
Number of health networks that proceeded with contracting	2

Last CalOptima Network RFP (cont.)

- Lessons Learned
  - Last RFP for additional health networks resulted in only 2 out of 12 respondents being added through the RFP and contracting process
    - However, one of the two contracted health networks has not met the minimum membership requirement of 5,000 members after three years
    - Since the health network has failed to meet this requirement, a termination notice is anticipated
  - Significant administrative workload to process all RFP responses
    - Very low execution rate from RFP to sustainable network contract
      - Low membership after 3 years for the 2 new health networks
  - Unlikely that any new health network could reach the minimum membership requirement (5,000) without adding new member population
    - Members would have to transfer from other health networks or CCN
      - By member choice only
    - Auto-assignment could be minimal as performance measures may not exist for the first year

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Delivery System Metrics

Medi-Cal Membership by Network – July 2018

Health Network	Model	Enrollment	% Total
CHOC Health Alliance	PHC	146,549	19.4%
COD – CalOptima	FFS	104,533	13.8%
Monarch Family Healthcare	HMO	81,235	10.7%
CCN – CalOptima	FFS	75,618	10.0%
Arta Western	SRG	65,592	8.7%
Alta Med Health Services	SRG	46,335	6.1%
Family Choice Health Network	PHC	46,227	6.1%
Kaiser Permanente	HMO	45,659	6.0%
Prospect Medical Group	HMO	33,989	4.5%
United Care Medical Network	SRG	32,334	4.3%
Noble	SRG	24,798	3.3%
Talbert Medical Group	SRG	23,889	3.2%
AMVI Care Health Network	PHC	22,386	3.0%
Heritage – Regal Medical Group	HMO	5,863	0.8%
OC Advantage	PHC	2,126	0.3%
Total Medi-Cal Enrollment Only		**757,133**	**100.0%**

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Delivery System Metrics (cont.)

Contracted Medi-Cal Providers by Network

Health Network	Orange County PCPs	Network Unique PCPs		Overlap with Other Networks	
		Count	%	Count	%
Alta Med Health Services	110	7	6.4%	103	93.6%
AMVI Care Health Network	79	2	2.5%	77	97.5%
Arta Western	255	6	2.4%	249	97.6%
CHOC Health Alliance	425	33	7.8%	392	92.2%
CCN – CalOptima	598	107	17.9%	491	82.1%
Family Choice Health Network	174	11	6.3%	163	93.7%
Heritage – Regal Medical Group	332	40	12.0%	292	88.0%
Monarch Family Healthcare	315	56	17.8%	259	82.2%
Noble	116	6	5.2%	110	94.8%
OC Advantage	75	4	5.3%	71	94.7%
Prospect Medical Group	236	21	8.9%	215	91.1%
Talbert Medical Group	234	36	15.4%	198	84.6%
United Care Medical Network	186	49	26.3%	137	73.7%
Total PCP's	**1,068**				

Notes: Each PCP count represents unique PCP physicians; a PCP may be affiliated with one or more networks
Kaiser is excluded from the data
Overlap – PCP is available for selection from at least two entities at minimum

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Delivery System Metrics (cont.)

Contracted Hospitals by Network – Summary

Health Network	Model	Total Hospital Affiliations
CCN/COD/SRGs	FFS	30*
Monarch Family Healthcare	HMO	14
Heritage – Regal Medical Group	HMO	8
CHOC Health Alliance	PHC	6
Prospect Medical Group	HMO	5
Family Choice Health Network	PHC	1
AMVI Care Health Network	PHC	1
OC Advantage	PHC	1

* 9 of the 30 total hospitals are only affiliated with CCN/COD/SRG CalOptima is at risk for hospital costs related to CCN/COD/SRGs. SRGs are not contracted directly with these hospitals for CalOptima members.

Delivery System Metrics (cont.)

Contracted Hospitals by Network – Detail

Hospital	CCN/COD SRG	Monarch	Heritage Regal	CHOC	Prospect	Family Choice	AMVI	OC Ad-vantage	Total
	FFS	HMO	HMO	PHC	HMO	PHC	PHC	PHC	
Anaheim Global Medical Center	1								1
Anaheim Regional Medical Center	1	1			1				3
Chapman Global Medical Center	1	1							2
Children's Hospital of Orange County	1			1					2
CHOC Children's at Mission Hospital	1	1		1					3
College Hospital – Cerritos	1								1
College Hospital Costa Mesa	1		1						2
Foothill Regional Medical Center	1				1				2
Fountain Valley Regional Hospital & Medical Center	1	1	1		1	1	1	1	7
Garden Grove Hospital and Medical Center	1								1
Healthbridge Children's Hospital – Orange	1								1
Hoag Memorial Hospital Presbyterian	1			1					2
Huntington Beach Hospital	1	1							2
Kindred Hospital – Brea	1								1
Kindred Hospital – Santa Ana	1		1						2
Kindred Hospital – Westminster	1		1						2
Long Beach Memorial Medical Center	1	1							2

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Delivery System Metrics (cont.)

Contracted Hospitals by Network – Detail (cont.)

Hospital	CCN/COD SRG	Monarch	Heritage Regal	CHOC	Prospect	Family Choice	AMVI	OC Ad-vantage	Total
	FFS	HMO	HMO	PHC	HMO	PHC	PHC	PHC	
Long Beach Memorial Medical Center Miller Children's	1	1							2
Los Alamitos Medical Center	1	1	1		1				4
Mission Hospital Regional Medical Center	1	1		1					3
Orange County Global Medical Center	1	1	1						3
Placentia Linda Hospital	1	1	1		1				4
Prime HealthCare La Palma Intercommunity Hospital	1	1							2
Promise Hospital of East Los Angeles LP	1								1
South Coast Global Medical Center	1	1	1	1					4
St. Joseph Hospital	1			1					2
St. Jude Medical Center	1								1
UCI Medical Center	1								1
West Anaheim Medical Center	1	1							2
Whittier Hospital Medical Center	1								1
Total	**30**	**14**	**8**	**6**	**5**	**1**	**1**	**1**	

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Quality/ HEDIS Metrics

Raw Scores by Measure

	Adult Access to Preventive Care Services	Adolescent Well Care Visits	Breast Cancer Screening	Children's Access to Primary Care Physician	Cervical Cancer Screening	Diabetes Care: Eye Exam
CCN	71%	37%	55%	78%	53%	49%
Health Network 1	58%	59%		90%		67%
Health Network 2	69%	45%	66%	86%	59%	62%
Health Network 3	72%	48%	64%	88%	58%	56%
Health Network 4	60%	72%	69%	91%	63%	59%
Health Network 5	67%	49%	66%	80%	57%	59%
Health Network 6	62%	41%	63%	82%	51%	65%
Health Network 7	71%	53%	65%	87%	60%	52%
Health Network 8	68%	24%		75%	47%	62%
Health Network 9	57%	49%	64%	82%	55%	72%
Health Network 10	63%	52%	64%	88%	52%	57%
Health Network 11	66%	26%			48%	59%
Health Network 12	51%	44%	49%	81%	42%	55%

Based on 2017 measurement results

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Quality/ HEDIS Metrics (cont.)

Raw Scores by Measure (cont.)

	Diabetes Care: HbA1c Screening	Childhood Immunizations Combo 10	Appropriate Treatment for Children with Pharyngitis	Medication Management for People with Asthma	Appropriate Treatment for Children with URI	Well Child Visits 3-6 years
CCN	84%	27%	58%	42%	94%	64%
Health Network 1	92%	31%	57%	34%	94%	80%
Health Network 2	87%	20%	51%	56%	93%	76%
Health Network 3	86%	21%	54%	46%	90%	79%
Health Network 4	87%	22%	19%	39%	91%	84%
Health Network 5	87%	39%	33%	42%	94%	75%
Health Network 6	87%	17%	74%	44%	92%	69%
Health Network 7	88%	26%	37%	35%	92%	74%
Health Network 8	88%				76%	50%
Health Network 9	88%	28%	41%	35%	91%	70%
Health Network 10	85%	20%	46%	40%	93%	73%
Health Network 11	90%					
Health Network 12	80%	27%	53%	49%	93%	69%

Based on 2017 measurement results

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Financial Metrics

Medi-Cal MLR Audit Results – Summary

	Combined 3-year Average (CY 2014-2016)
Total Health Networks	13
Health Networks <85% MLR	3

- Medical Loss Ratio (MLR) is only applicable to capitation
  - Contract requirement – to ensure at least 85% of their capitation payment is spent on medical care
    - Capitation rates are risk adjusted by CalOptima to account for member acuity/cost variation
- CCN is not a capitated health network
  - However, health networks are capitated based on the FFS rates that CCN pays providers
  - In addition, health networks are given a 10-15% administrative load in their capitation rates

Financial Metrics (cont.)

Medi-Cal MLR Audit Results by Network

Health Network	Combined 3-year Average (CY 2014-16)
Health Network 1	75%*
Health Network 2	89%
Health Network 3	88%
Health Network 4	85%
Health Network 5	94%
Health Network 6	86%
Health Network 7	117%
Health Network 8	89%
Health Network 9	85%
Health Network 10	72%*
Health Network 11	79%*
Health Network 12	96%
Health Network 13	85%
Average	**91%**

* Health network is under corrective action for not meeting 85% minimum MLR requirement

Health Network Requirements – 2015 RFP

- Minimum New Health Network Requirements
  - Physician network requirements
    - 95% of primary care physicians must practice in Orange County
    - 50% of physicians must be specialists
    - 20% of physicians are not currently affiliated with any existing CalOptima delegated health network
  - Participate in all CalOptima programs
    - Medi-Cal, OneCare and OneCare Connect
  - Qualify to participate in an established health delivery model
    - SRG: Shared Risk Group
    - PHC: Physician and Hospital risk sharing partnership
    - HMO: Full risk health network and Knox-Keene licensed medical groups
  - Demonstrate medical, quality, administrative, operational and financial readiness as described in the Statement of Work (SOW)

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Health Network Requirements – Contract

- Fulfill and comply with all requirements of:
  - CalOptima Readiness Assessment
  - CalOptima Policies and Procedures
  - CMS, DHCS and NCQA

- Agree to:
  - CalOptima contractual terms
  - CalOptima reimbursement methodology and capitation rates
  - Divisions of financial responsibility (DOFRs)
  - Participate in all state and federal audits and corrective action plans
  - Participate in CalOptima's Quality, Utilization Management and oversight programs
  - Requirements of the Delegation and Business Associate Agreements

Summary/ Considerations

- Market
  - New health networks must share auto-assignments with other existing health networks which makes growth very slow
  - New health networks may also add members if existing members in other health networks choose to move; also a slow growth process
  - The addition of new health network will not add new Medi-Cal members to CalOptima
- Member
  - New health network would receive members by choice or through the auto-assignment process
    - Auto assignment would be minimal the first year, as performance measures might not exist or qualify to be measurable
    - Difficult for health network to meet minimum membership – either by member choice or by auto-assignment
  - Member always has the choice to select a different health network or CCN each month
  - Changes in health networks could create significant member disruption

Summary/ Considerations (cont.)

- Provider
  - CalOptima has 100% of providers who want to participate in Medi-Cal
  - All health networks willing to contract with new providers based on need
  - CCN/COD network accepts any willing and qualified provider as long as they meet and agree to the contract standards and requirements
  - Result: Providers have opportunity through health networks and CCN/COD to participate in CalOptima
- Financial
  - CalOptima sets the payments rates
  - CalOptima sets the performance standards and completes periodic reviews and audits to ensure compliance and enforce contract terms
  - Result: CalOptima ensures the delegation of risk to a health network is appropriate
- Regulatory
  - DHCS contract requires written approval prior to making any substantial changes in the availability or location of covered services

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Auto-Assignment – Summary

Member Advisory Committee (MAC) Meeting
September 13, 2018

Greg Hamblin, Chief Financial Officer

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Overview

- Auto-Assignment Policy
  - Overview of Policy
  - Performance Criteria
  - Performance Based Ranking
  - Auto-Assignment Retention Rates
- Other Quality Metrics
- Medi-Cal Enrollment by Network
- Financial Information/Considerations
- Current Policy Impact
- Policy Change Impact

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Auto-Assignment Policy

- The CalOptima Auto-Assignment Policy was structured to ensure the following:
  1. Members have access to health care services in geographic proximity to his or her residence.
  2. Community Health Center Safety Net provider participation in the CalOptima program.
     - Community Clinics
     - FQHCs
  3. Member assignment to Health Network or CCN based on performance criteria.
     - Auto-Assignment Limitation
       - Health Network maximum enrollment not to exceed 33.33% of total health network eligible members
       - CCN maximum enrollment not to exceed 10.00% of total health network eligible members
       - Auto-assignment is turned off once the maximum enrollment is reached

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Auto-Assignment Policy (cont.)

- On average ~7,000 new/returning members are auto-assigned each month
  - Assignment is based on geographic zip code locations and performance based criteria
  - Members can request to change their Health Network or CCN affiliation once per month

- Of the ~7,000 members being auto-assigned:
  - 45% or ~3,150 are auto-assigned to the Clinics/ FQHCs
    - Each Clinic/ FQHC can selected a Health Network affiliation or CCN affiliation in order to receive its allocation of auto-assigned members
    - Currently, all Clinics/ FQHCs are affiliated with the Health Networks for auto-assignment

Auto-Assignment Policy (cont.)

- 55% or ~3,850 are auto-assigned to a Health Network or CCN
  - Currently, the Health Networks receive all auto-assignment as CCN auto-assignment is turned off based on the maximum enrollment limitation set by policy
  - Auto-assignment is based on a Health Network's or CCN's, performance-based criteria and resulting ranking
  - Performance Criteria
    - Specific performance indicators have been established
    - Each performance indicator is assigned a weight % and points
    - Relative ranking is based on the sum of weighted scores for all indicators
    - The ranking, in numerical sequence, is used as the processing order for auto-assignment
    - Results take effect the following year for a one year period

Performance Criteria

Category	Indicator	Possible Points	Weight
Quality of Clinical Service	Well Child Visits: 3rd, 4th, 5th, 6th Years	0, 2, 5, 10	10%
	Adolescent Well-Care Visits	0, 2, 5, 10	10%
	HbA1c Testing/ Well Child Visit – 15 months	0, 2, 5, 10	10%
	Postpartum Care/ Childhood Immunization Combo 2	0, 2, 5, 10	10%
	Breast Cancer Screening/ Child Immunization MMR	0, 2, 5, 10	10%
	LDL Screening/ Appropriate Treatment Children URI	0, 2, 5, 10	10%
Administrative Excellence	Child Member Satisfaction Survey	0, 4, 10, 20	20%
	Encounters	0, 2, 5, 10	10%
	Auto-Assignment Retention Rate	0, 2, 5, 10	10%
	Total		100%

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Performance Based Ranking

Current Ranking	Medi-Cal	
	Weighting %	Relative Ranking
Health Network A	13.4%	1
Health Network B	11.1%	2
Health Network C	10.8%	3
Health Network D	9.6%	4
Health Network E	9.5%	5
Health Network F	9.1%	6
Health Network G	8.1%	7
Health Network H	7.5%	8
CCN	**6.8%**	**9**
Health Network I	5.4%	10
Health Network J	4.8%	11
Health Network K	2.9%	12
Health Network L	1.0%	13

As of January 1, 2018
Note: Kaiser is excluded from auto-assignment

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Auto-Assignment Retention Rates

- Data Source: Auto-assignments from July 2016 – March 2017
  - CCN auto-assignment was closed effective April 2017
- Measures members initially auto-assigned and their retention rate on a quarterly basis; up to a maximum of 8 quarters (2 years)
  - Measured through June 2018
- Finding: On average, CCN retention rate was 8% to 9% higher than the Health Network rate for each period

Period	Health Network	CCN	Difference
One quarter	74%	82%	8%
Two quarters	60%	69%	9%
Three quarters	52%	61%	9%
Four quarters	42%	53%	11%
Five quarters	36%	45%	9%
Six quarters	33%	41%	8%
Seven quarters	31%	40%	9%
Eight quarters	25%	33%	8%

Medi-Cal Enrollment by Network (July 2018)

Health Network	Model	Enrollment	% Total
CHOC Health Alliance	PHC	146,549	22.5%
Monarch Family Healthcare	HMO	81,235	12.4%
CCN – CalOptima (Auto-assignment turned off)	**FFS**	**75,618**	**11.6%**
Arta Western	SRG	65,592	10.1%
Alta Med Health Services	SRG	46,335	7.1%
Family Choice Health Network	SRG	46,227	7.1%
Kaiser (No Auto-assignment by choice)	HMO	45,659	7.0%
Prospect Medical Group	HMO	33,989	5.2%
United Care Medical Network	SRG	32,334	5.0%
Noble	SRG	24,798	3.8%
Talbert Medical Group	SRG	23,889	3.7%
AMVI Care Health Network	PHC	22,386	3.4%
Heritage – Regal Medical Group	HMO	5,863	0.9%
OC Advantage	PHC	2,126	0.3%
Total Health Network Enrollment		**652,600**	**100.0%**
CalOptima Direct (No Auto-assignment)	FFS	**104,533**	
Total Medi-Cal Enrollment		**757,133**	

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Financial Information/Considerations

- 2 different Payment Models
  1. Capitation
     - PMPM is paid to a Health Network for each enrolled member
       - Capitation PMPM rates are based on CalOptima's Fee-For-Service (FFS) payment policies, methodologies and fee schedules using actual, historical incurred utilization rates
       - HMO/PHC – Capitation paid for certain Professional & Hospital services (some carve outs and re-insurance paid on FFS basis)
       - SRG – Capitation paid for certain Professional services (some carve outs and re-insurance paid on FFS basis)
  2. Fee-For-Service (FFS)
     - Provider is paid a fee for each particular service performed
       - FFS payment rates are based on CalOptima's payment policies, methodologies and fee schedules
       - CCN – Payments made on FFS basis

  ➢ Capitation rates are based on the same payment policies, methodologies and rates experienced under FFS

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Financial Information/Considerations

3. Administrative Expenses

- Capitation
  - CalOptima includes an Administrative and Medical Management load as part of the capitation rate paid to the health networks
  - The Administrative load rate is developed based on CalOptima FFS administrative and medical management costs
  - Delegated health networks only perform some of the administrative functions that CalOptima performs
  - The administrative and medical management costs that CalOptima includes as part of the capitated rates are equivalent to the incurred administrative and medical management costs experienced under FFS

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Current Policy Impact

- Under the current policy, auto-assignment to CCN is turned off when the total number of CCN members exceeds 10% of Eligible Network Enrollment
  - CCN auto-assignment was closed effective April 2017
    - Limitation is currently still in place with 0% auto-assignment to CCN
  - CCN Current enrollment is 75,618
    - 652,600 Total members x 10% = 65,260 limitation threshold

- Currently, all auto-assignment (~7,000 per month) is through the Health Networks
  - ~3,150 or 45% to Clinic/ FQHC: Selected Health Network affiliation
  - ~3,850 or 55% to Health Networks

Policy Change Impact

- Removing the 10% Auto-assignment limitation from CCN
  - Annualized impact based on current data:
    - CCN would receive ~3,600 or 7.8% of the available members through Auto-Assignment
    - Health Networks would receive ~42,600 or 92.2% of the available members through Auto-Assignment
  - Auto-assignment member loss will significantly mitigate these numbers
    - Retention rates:
      - At the end of 4 quarters: 42% Health Network and 51% CCN
      - At the end of 8 quarters: 25% Health Network and 33% CCN
    - Member loss from auto-assignment could be due to:
      - Member choice: selecting another Health Network or CCN
      - Loss of Medi-Cal coverage
  - There would be no significant financial impact to CalOptima due to this policy change at this level of membership and historical retention rates

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MEMORANDUM

DATE:	September 6, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

CalOptima Earns Accreditation at the Commendable Level
I am proud to announce great news about CalOptima's ongoing commitment to quality. As a result of our National Committee for Quality Assurance (NCQA) reaccreditation audit in July, CalOptima was awarded NCQA accreditation at the commendable level. According to the NCQA, commendable status is afforded to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This outstanding agencywide achievement will be in effect for three years. I sincerely appreciate your Board's support for all the programs and policies that enable CalOptima to maintain our dedication to quality care.

Medi-Cal Audit Results Reflect Commitment to Compliance
CalOptima completed a successful annual Department of Health Care Services (DHCS) Medi-Cal audit, with the regulator's August 27 draft report showing just one finding. The audit evaluated CalOptima's compliance with our contract and regulations in several areas: utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, internal organization and administration, facility site reviews, and medical records review. The single finding was in case management and care coordination for behavioral health, and the finding is in the process of being corrected with new policies your Board will consider this month. The audit covered the period February 1, 2017, through January 31, 2018.

Whole-Child Model Family Advisory Committee (WCM FAC) Holds Inaugural Meeting
On August 9, CalOptima officially launched the WCM FAC, our newest advisory committee, which will be instrumental in helping us prepare for the upcoming transition of California Children's Services. Seven committee members attended, and the meeting included an update on our implementation efforts as well as an open discussion of topics for future meetings. Also, Pam Patterson was chosen by the group to serve as interim chair until the next meeting in October, when a chair and vice chair will be elected.

CalOptima Engages Providers to Ensure Their Enrollment in Medi-Cal
Driven by the federal Mega Reg and a state All Plan Letter, all Medi-Cal providers and provider groups must be officially enrolled in the Medi-Cal program by January 1, 2019. Among the goals is reducing fraud, waste and abuse by having more strict enrollment records. CalOptima has been outreaching to non-enrolled providers and groups in letters, calls and office visits, and many

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have worked to get enrolled. However, at this time, approximately 100 of our 1,600 primary care providers have yet to complete the process, and these providers care for approximately 40,000 members. Because regulatory requirements require contracts with non-enrolled providers to be terminated as of January 1, it is possible that some members may need to be reassigned in 2019.

Annual Network Certification Confirms the Strength of CalOptima's Provider Network
Passed in October 2017 to implement a major provision of the federal Mega Reg, Assembly Bill 205 now requires DHCS to publish the outcome of Medi-Cal managed care plans' annual network certification, including noncompliance with time and distance standards. Upon DHCS review, CalOptima's robust provider network met all the requirements. This achievement is not universal among health plans, and a report released by the state in July detailed the corrective actions needed at nine commercial and public Medi-Cal managed care plans. Time and distance standards are important for quality care, reflecting how long members must wait for available appointments and how far they must travel to see their doctors.

Program of All-Inclusive Care for the Elderly (PACE) to Host Anniversary Event
CalOptima is strengthening our relationship with PACE participants in a special event celebrating our program's fifth anniversary. On Saturday, September 29, PACE staff will join with participants and their families to enjoy activities and entertainment.

KEY MEETINGS

- **America's Health Insurance Plans (AHIP) CEO Visits CalOptima**
  As a new AHIP member, CalOptima welcomed CEO Matt Eyles in late August for an introductory visit. AHIP is the largest organization representing health insurers, and it is making a concerted effort to expand services for Medicaid plans. Matt and I discussed AHIP resources and advocacy efforts as well as the prospect of federal Medicaid reforms.
- **Community Health Center Visits Highlight Orange County Safety Net**
  To honor our partnerships with community health centers, I participated in National Health Center Week in August. Along with Isabel Becerra, CEO of the Coalition of Orange County Community Health Centers, I toured Camino Health Center in Lake Forest and Serve the People in Santa Ana, two of our valued Federally Qualified Health Centers. These safety net facilities are responsible for delivering quality services to thousands of CalOptima members.
- **CalOptima Joins Hispanic Chamber of Commerce**
  CalOptima recently became a member of the Hispanic Chamber of Commerce, and on August 3, I spoke briefly at a meeting with chamber members held at our offices. I highlighted our shared mission of enhancing the lives of Orange County's Hispanic population. The chamber represents 30,000 Hispanic-owned businesses, and CalOptima serves more than 358,000 members who identify as Hispanic.
- **Orange County Group Seeks Better Behavioral Health System**
  On August 10, I attended the Be Well Summit at Saddleback Church in San Juan Capistrano. The meeting gathered approximately 70 local public and private-sector leaders to consider improvements to Orange County's system for behavioral health.

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Medi-Cal

CalOptima

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Health Homes Program (HHP)

Member Advisory Committee
September 13, 2018

Candice Gomez, Executive Director
Program Implementation

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HHP Background: Authorization

- Federal: Authorized under Section 2703 of the Affordable Care Act (ACA)
  - State option to implement
  - 90 percent funding for eight quarters and 50 percent thereafter
  - Must be available to dual eligible
- State: California's AB 361 (2013) authorizes HHP participation
  - Implementation permitted if no General Funds used
  - Requires Department of Health Care Services (DHCS) evaluation within two years of state's initial implementation
- CalOptima scheduled to Go-Live:
  - July 1, 2019: Members with chronic conditions
  - January 1, 2020: Members with Serious Mental Illnesses or Serious Emotional Disturbance (SMI)

DHCS HHP California Model

Department of Health Care Services

Lead Entities

Qualifying Medi-Cal managed care plans (MCP)
Orange County: CalOptima

Community-Based Care Management Entities (CB-CMEs)

Sample organizations include Primary Care Providers Federally Qualified Health Centers, physician groups, hospitals and behavioral health entities or MCP

Community and Social Support Services

Sample organizations include supportive housing providers, food banks, employment assistance and social services

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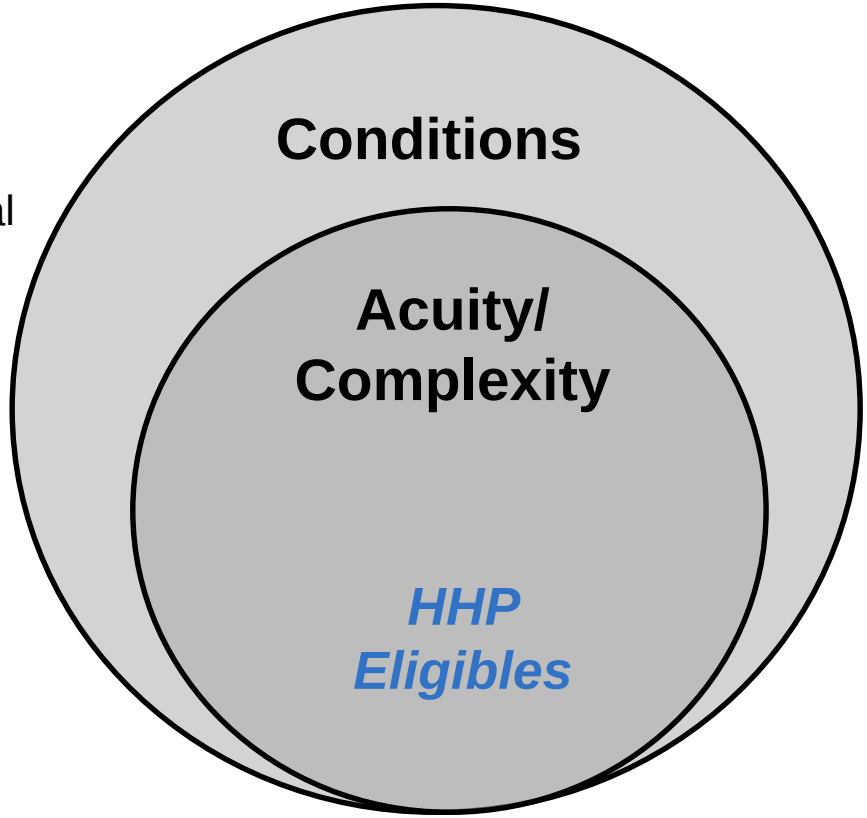
DHCS HHP Member Eligibility

- Medi-Cal members eligible for HHP

1. Conditions/combination of conditions specified by DHCS
   - Chronic physical conditions, including substance use disorder or
   - Serious mental illness/Serious emotional disorder

2. Acuity/complexity (**one** of the below):
   - Three specified conditions
   - One inpatient stay
   - Three Emergency Department (ED) visits in year
   - Chronic homelessness



HHP Member Exclusions

- Residing in nursing facility (NF)
- Enrolled in hospice
- Participating in other programs (member must choose as they cannot participate in both)
  - Most county-operated Targeted Case Management (TCM), not Mental Health TCM
  - 1915(c) Waiver programs including HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC)
  - PACE
  - Cal MediConnect

Demographics

Languages	Gender
English — 72% Spanish — 21% Vietnamese — 5%	Female — 55% Male — 45%

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Health Network Distribution Based on DHCS Data

Active Outreach		DHCS Assumed Opt-In Rate	CalOptima Assumed Opt-In Rate		
Health Network	**Count**	**Targeted 25%**	**20%**	**15%**	**10%**
Monarch	4,774	1,194	955	716	477
CCN	4,761	1,190	952	714	476
CHOC	3,937	984	787	591	394
Arta	3,050	763	610	458	305
Kaiser	2,096	524	419	314	210
AltaMed	2,048	512	410	307	205
Prospect	1,580	395	316	237	158
Family Choice	1,420	355	284	213	142
Talbert	1,225	306	245	184	123
Noble	1,148	287	230	172	115
United	950	238	190	143	95
AMVI	538	135	108	81	54
HPN Regal	236	59	47	35	24
OC Advantage	44	11	9	7	4
Totals	**27,807**	**6,952**	**5,561**	**4,171**	**2,781**

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HHP Service Requirements

Enhanced Core Service Categories	New Services
• Provide comprehensive care management	• Follow up on referrals to ensure services are offered and accessed
• Conduct health assessments and develop action plans	• Accompany highest risk participants to critical appointments (risk tier criterion determined by MCP)
• Provide comprehensive transitional care	• Assist homeless members with housing navigation
• Offer care coordination and health promotion	• Manage transitions from non-hospital or nursing facility settings, such as jail and residential treatment programs
• Offer individual and family support	• Assess family/caregiver support
• Make referrals to community and social support services	• Develop trauma informed care standards

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HHP CB-CME Staffing

- Clinical Consultant
- HHP Director
- Dedicated Care Coordinator
  - 60:1 member to Care Coordination ratio expected after two years
- Housing Navigator for members experiencing homelessness
- Community Health Worker recommended but not required

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Community Services Analysis

- External consultant conducted survey of Orange County community-based organizations (CBOs) providing HHP-like services
  - Surveys conducted September–November 2017

- Results
  - 48 of 72 CBOs responded to survey
    - 14 were Federally Qualified Health Center (FQHC)/Clinics and substantially completed the survey
  - Six community-based organizations with a total 27 sites providing most or all HHP-like services
    - Covering all cities with high-density of potential HHP members projected
    - Four identified as FQHCs or medical clinics

Approach

- CalOptima acts as CB-CME for all Health Networks (HN) and CalOptima Direct/CalOptima Community Network (COD/CCN) members
  - Exception: Health networks may elect to provide CB-CME services for their assigned members
  - Members electing to participate in HHP will move to CCN or electing HN
  - CalOptima to “buy” select “new” services that may be leveraged by health networks, e.g., housing related services and accompaniment

CalOptima's Mission

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

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Intergovernmental Transfer (IGT) Funds Timeline*

IGT 5 Community Grants — $14.4 Million

June 8, 2018	Release Requests for Information (RFIs) — *completed*
July 9, 2018	RFI responses due — *completed*
October 2018	Release 11 Requests for Proposal (RFPs)
December 2018	RFP responses due
February 2019	Award grants

IGT 6/7 Community Grants — $17.7 Million

October 19, 2017	Release Letters of Interest/Information (LOIs) — *completed*
November 13, 2017	LOI responses due — *completed*
September 2018	Release 6 Requests for Proposal (RFPs)
November 2018	RFP responses due
February 2019	Award grants

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IGT 8 ≈ $40 Million

Use of funds to be approved by CalOptima Board of Directors.
Funds must be used for Medi-Cal covered services.

January 2019	Funds anticipated to be received by CalOptima

IGT 9 ≈ $40 Million

Use of funds to be approved by CalOptima Board of Directors.
Funds must be used for Medi-Cal covered services.

Timeline for funds availability is not currently available.

**All dates are tentative*

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HEDIS® 2018 Results

(MY 2017 Performance)

Member Advisory Committee
September 13, 2018

Irma Munoz
Lead Project Manager, Quality Analytics (HEDIS)

Marsha Choo
Manager, Quality Analytics (Quality Initiatives)

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What is HEDIS?

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement tool used by health plans to reliably compare how they perform on important dimensions of care and service.
- HEDIS makes it possible to compare performance on an “apples-to-apples” basis to national benchmarks in more than 91 measures across seven domains of care
- All HEDIS results are independently audited annually
- Results are calculated and reported annually

How did CalOptima perform? (2017 results)

- Medi-Cal
  - **All DHCS Minimum Performance Levels have been met !!**
  - 35 of 62 (56 percent) measures met goal (vs. 44 percent last year)
  - 48 of 62 (76 percent) measures are better than last year (72 percent)
  - Opportunities for Improvement: Respiratory, Cardiovascular and Access of Care measures
- OneCare
  - 56 percent of measures met goal (vs. 62 percent last year)
  - 74 percent measures are better than last year (67 percent)
  - Opportunities for Improvement: Diabetes Nephropathy and Breast Cancer Screening

*Goals were set to the next higher NCQA percentile based on previous performance. Some goals were "stretch goals."

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How did CalOptima perform? (2017 results) (cont.)

- OneCare Connect
  - 33 percent measures met goal
  - 74 percent measures are better than last year
  - Opportunities for Improvement: Diabetes and Behavioral Health measures

*Goals were set to the next higher NCQA percentile based on previous performance. Some goals were “stretch goals.”

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NCQA Percentiles Achievement

LOB	HEDIS	Number of Measures at NCQA National Medicaid/Medicare Percentiles										Total # of measures*	Percent of measures at National 50th percentile or higher
		90th Percentile		75th Percentile		50th Percentile		25th Percentile		<=10th Percentile			
		# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures		
Medi-Cal	2018	13	21%	17	27%	15	24%	9	15%	8	13%	62	73%
	2017	6	10%	12	19%	22	35%	13	21%	9	15%	62	65%
OneCare	2018	1	4%	5	19%	11	41%	5	19%	5	19%	27	63%
	2017	0	0%	5	19%	7	26%	8	30%	7	26%	27	44%
OneCare Connect	2018	2	5%	1	3%	12	31%	16	41%	8	21%	39	38%
	2017	1	3%	1	3%	11	28%	15	38%	11	28%	39	33%

*reported measures in the domains of Effectiveness of Care and Access/Availability of Care only

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Select HEDIS 2018 Medi-Cal Measures

	National Medicaid 50th percentile	CalOptima 2018 Rate	CalOptima 2018 Rate compared to 50th percentile
Adult BMI Assessment	86.24%	**95.00%**	↑
Weight Assessment and Counseling for Children/Adolescents — (BMI)	72.22%	**90.32%**	↑
Weight Assessment and Counseling for Children/Adolescents — (Nutrition)	68.05%	**87.10%**	↑
Weight Assessment and Counseling for Children/Adolescents — (Physical Activity)	59.26%	**80.65%**	↑
Childhood Immunization Status — (combo 10)	33.09%	**45.01%**	↑
Immunization for Adolescents — (combo 2)	19.79%	**49.39%**	↑
Comprehensive Diabetes Care — (HbA1c Testing)	87.10%	**90.75%**	↑
Comprehensive Diabetes Care — HbA1c Poor Control — (>9.0%)*	41.12%	**22.87%**	↑
Comprehensive Diabetes Care — HbA1c Control — (<8.0%)	48.87%	**63.99%**	↑
Comprehensive Diabetes Care — (Eye Exam)	55.11%	**65.94%**	↑
Comprehensive Diabetes Care — (Medical Attention for Nephropathy)	90.27%	**91.73%**	↑
Comprehensive Diabetes Care — (Blood Pressure Controlled <140/90 mm Hg)	60.60%	**72.26%**	↑

Lower rate indicates better performance

Green=higher than last year; Red=lower than last year

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CalOptima A Public Agency Better. Together.

Select HEDIS 2018 Medi-Cal Measures

	National Medicaid 50th percentile	CalOptima 2018 Rate	CalOptima 2018 Rate compared to 50th percentile
Well-Child Visits in the First 15 Months of Life — (6+ visits)	62.06%	**48.18%**	↓
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	72.45%	**83.15%**	↑
Adolescent Well-Care Visits	50.12%	**51.11%**	↑
Controlling High-Blood Pressure	56.93%	**69.59%**	↑
Prenatal and Postpartum Care — (Timeliness of Prenatal Care)	83.56%	**86.16%**	↑
Prenatal and Postpartum Care — (Postpartum Care)	64.38%	**71.75%**	↑
Lead Screening in Children	71.38%	**77.86%**	↑
Breast Cancer Screening	58.99%	**63.73%**	↑
Cervical Cancer Screening	58.48%	**60.24%**	↑

Lower rate indicates better performance

Green=higher than last year; Red=lower than last year

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CalOptima A Public Agency Better. Together.

OneCare Results

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Select HEDIS 2018 OneCare Measures

	National Medicaid 50th percentile	CalOptima 2018 Rate	CalOptima 2018 Rate compared to 50th percentile
Comprehensive Diabetes Care — (HbA1c Testing)	93.82%	**90.32%**	↓
Comprehensive Diabetes Care – (HbA1c Poor Control >9.0%)*	22.95%	**18.95%**	↑
Comprehensive Diabetes Care — HbA1c Control (<8.0%)	64.72%	**76.61%**	↑
Comprehensive Diabetes Care — (Eye Exam)	70.91%	**76.61%**	↑
Comprehensive Diabetes Care — (Medical Attention for Nephropathy)	95.86%	**89.52%**	↓
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	65.82%	**79.03%**	↑
Controlling High Blood Pressure	69.90%	**76.14%**	↑
Care for Older Adults — (Pain Screening)	N/A	**88.16%**	
Care for Older Adults — (Medication Review)	N/A	**90.13%**	
Colorectal Cancer Screening	68.09%	**63.07%**	↓

Lower rate indicates better performance

Green=higher than last year; Red=lower than last year

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CalOptima A Public Agency Better. Together.

OneCare Connect Results

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Select HEDIS 2018 OneCare Connect Measures

	National Medicaid 50th percentile	CalOptima 2018 Rate	CalOptima 2018 Rate compared to 50th percentile
Comprehensive Diabetes Care — (HbA1c Testing)	93.82%	90.05%	↓
Comprehensive Diabetes Care — (HbA1c Poor Control >9.0%)*	22.91%	21.94%	↑
Comprehensive Diabetes Care — (HbA1c Control <8.0%)	64.72%	70.15%	↑
Comprehensive Diabetes Care — (Eye Exam)	70.91%	77.55%	↑
Comprehensive Diabetes Care — (Medical Attention for Nephropathy)	95.86%	95.15%	↓
Comprehensive Diabetes Care — (Blood Pressure Controlled <140/90 mm Hg)	65.82%	69.90%	↑
Controlling High Blood Pressure	69.90%	76.72%	↑
Care for Older Adults — (Pain Screening)	N/A	75.67%	
Care for Older Adults — (Medication Review)	N/A	79.81%	
Colorectal Cancer Screening	68.09%	61.99%	↓
Breast Cancer Screening	72.22%	66.93%	↓
Follow up After Hospitalization for Mental Illness — (30-days)	52.40%	46.81%	↓

*Lower rate indicates better performance

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Green=higher than last year; Red=lower than last year

Medi-Cal Member Experience (CAHPS)

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Member Experience Surveys

- Medi-Cal adult and child survey are conducted at plan level
  - Sample size for adult survey is 1,350; response rate was 24 percent
  - Sample size for child survey is 1,650; response rate was 28 percent
- Medi-Cal adult and child survey at the health network level are also conducted
  - Total adult survey sample size for all health networks is 17,183; overall response rate is 30 percent
  - Total child survey sample size for all health networks is 15,397; overall response rate is 37 percent

Member Experience Surveys (cont.)

- Medicare member experience surveys conducted for OneCare at plan level and OneCare Connect at both plan level and health network level
  - **Results for OC/OCC member experience surveys are not yet available**

Medi-Cal Adult Survey Results

- Results are consistent with last year (25th percentile)
- Pain points that keep us low scoring:
  - Member experience benchmarks have risen across the nation (bar continues to be raised)
  - "Rating of Health Plan" is double weighted; our score is at less than 25th percentile
  - Coordination of Care is statistically significantly lower than last year
  - Getting Needed Care, Getting Care Quickly, Rating of Specialist all stay at the < 25th percentile
  - There were three health networks with many areas statistically below the CalOptima average

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Medi-Cal Child Survey Results

- Results improved from the previous year
  - “Rating of Health Plan” is statistically significantly higher than the previous year
- Pain points that keep us low scoring:
  - Rating of Specialist is lower than the previous year
  - Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service continue to be areas of focus
  - There were two health networks with many areas statistically below the CalOptima average

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Medi-Cal CAHPS Adult and Child Member Survey Results

Measures	Adult		Child	
Overall Ratings and Composites	2018 Percentile	Benchmark Met / Not Met	2018 Percentile	Benchmark Met / Not Met
All Health Care	25th	Not Met	Below 25th	Not Met
Personal Doctor	Below 25th	Not Met	Below 25th	Not Met
Specialist Seen Most Often	Below 25th	Not Met	25th	Not Met
Health Plan/Program	25th	Not Met	Below 25th	Not Met
Getting Needed Care	Below 25th	Not Met	Below 25th	Not Met
Getting Care Quickly	Below 25th	Not Met	25th	Not Met
How Well Doctors Communicate	Below 25th	Not Met	25th	Not Met
Customer Service	Below 25th	Not Met	Below 25th	Not Met

Benchmark = 50th percentile (NCQA Quality Compass 2017 National Medicaid Percentiles)

Next Steps

- Implement strategies on low performing areas
  - Priority areas will include low areas of performance and areas related to strategic initiatives (DHCS MPL, NCQA Accreditation, NCQA Health Plan Ratings, Medicare Star Rating)
  - Member Experience Initiatives (provider coaching)
- Present results to stakeholder groups and committees
  - We will share the OCC Member Experience results when they are available — Q4
- Await NCQA Health Plan Rating results
- Begin preparations for HEDIS 2019!

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Mission Statement

The mission of CalOptima is to provide members with access to **quality health care** services delivered in a cost-effective and compassionate manner.

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Cultural & Linguistic Services Overview

Carlos Soto

Manager, Cultural & Linguistic Services

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Cultural & Linguistic Services

- No-Cost Translation Services
  - Member materials translated in CalOptima's threshold languages
  - Alternate formats, including braille, large font or audio
- No-Cost Interpreter Services
  - Telephonic interpreter services
  - Face-to-face interpreter services
  - California Relay and Telecommunication Device for the Deaf (TDD) for members with hearing and speech impairments

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Cultural & Linguistic Services (cont.)

- Importance of C&L Services Program
  - C&L addresses the linguistic and cultural barriers that Limited English Proficient (LEP) members face
  - Supports CalOptima's mission to provide access to quality health care services
  - Helps meet regulatory requirement for health plans and health providers

Orange County's C&L Needs

- There are unique needs in every Orange County region:
  - North County serves a large Latino and Vietnamese population.
  - Central County serves a predominantly Latino population.
  - West County serves a large Vietnamese population.
  - South County has an emerging Middle Eastern population.

C&L Goals and Objectives

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Cultural and Linguistic Services
2018 Goals and Objectives

GOALS AND OBJECTIVES				
GOALS	**OBJECTIVES**	**PERFOMANCE**	**IMPLEMENTATION TIMETABLE**	**ACCOMPLISHMENTS**
I. Conduct Awareness and Education Seminar (AES)	• Provide information and education on the cultural concerns and needs of CalOptima's Member population • Awareness and Education Seminar (AES), are be conducted on a quarterly basis	• Conduct Awareness and Education Seminar (AES) for CalOptima staff, health networks and providers, to inform and educate staff, health networks and providers on the cultural concerns and needs of CalOptima's Member population. • Attendees are asked to provide feedback regarding the seminar by completing an evaluation form	**Qtr. 1 AES** – Scheduled for March 2018 **Qtr. 2 AES** – Scheduled for May 2018 **Qtr. 3 AES** - Scheduled for August 2018 **Qtr. 4 AES** - Scheduled for October 2018	**Qtr. 1** – March 13, 2018; Optimizing a Member's Asthma Self-management. Evaluation was positive with an average 99% satisfaction rate. **Qtr. 2** – May 22, 2018; Diabetes Therapy Management. Evaluation was positive with an average 100% satisfaction rate, **Qtr. 3** – August 23, 2018; Adult Protective Services (APS): Recognizing, Reporting, and Responding to Alleged Abuse. Evaluation was positive with an average 99% satisfaction rate **Qtr. 4** – Pending, Topic TBD

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C&L Goals and Objectives (cont.)

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Cultural and Linguistic Services
2018 Goals and Objectives

II. CalOptima Staff Cultural & Linguistic **In-Service Training**	• Provide information, tips and resources regarding cultural needs and concerns that will allow the CalOptima staff members to assist with the cultural needs of CalOptima Members.	• Conduct annual Cultural & Linguistic (C&) annual In-Service trainings to CalOptima staff	• Annually	• In 2018 the following C&L In-Service presentations and trainings have been presented to the following departments: ▪ Behavioral Health • February 24, 2018 ▪ Medi-Cal Customer Service: • May 7, 2018 • May 13 6, 2018 • July 13, 2018
III. CalOptima New Hire Cultural &Linguistic Services Training	• Provide new employees with and overview of CalOptima's Cultural & Linguistics Program. The overview includes information on the cultural concerns and needs of CalOptima's M ember population	• Present C&L services at CalOptima Boot Camp trainings for new CalOptima staff. • Educate and provide information, tips and resources for new staff on the cultural needs of CalOptima's diverse M ember population	• Monthly	• In 2018 the following C&L services overview have been presented to new hires during the Boot Camp presentation: ▪ January 24, 2018 ▪ February 22, 2018 ▪ March 21, 2018 ▪ May 16, 2018 ▪ June 13, 2018 ▪ July 11, 2018

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C&L Goals and Objectives

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Cultural and Linguistic Services
2018 Goals and Objectives

IV. Translation of written member informing material & review documents for consistency	• Comply with regulatory mandated threshold language requirements by providing translation of written informing documents and materials in the members preferred language at no cost to the member. • Update CalOptima's multilingual glossaries	• Translate CalOptima Member informing materials in the required threshold languages. Written informing documents provide essential information regarding access and usage of Covered Services. • Ensure that informational or educational materials are available at in the required threshold languages at no-cost to members in alternative formats, such large-print, audio format, or Braille upon request Review and update CalOptima's multilingual glossaries to ensure consistency in the usage of translated terms by CalOptima staff and translation vendors.	• Daily • Glossaries are updated twice a year, January and July	• Year-to-Date (YTD) 2018 C&L has received 4,386 translation and review requests: ▪ Spanish 2,281 ▪ Vietnamese 641 ▪ Farsi 363 ▪ Korean 294 ▪ Arabic 463 ▪ Chinese 344 • The C&L glossaries were updated in February 2018 • The next update of the C&L glossaries is scheduled for October 2018

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C&L Goals and Objectives

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Cultural and Linguistic Services
2018 Goals and Objectives

V. Translation of Annual Notice of Change member materials	• Comply with regulatory requirements of translating all Annual Notice of change materials in the threshold languages and ensure that all member materials are in the member's hands by September 30th of each year as required by the Center for Medicare and Medicaid Services (CMS).	• OneCare and OneCare Connect Annual Notice of Change (ANOC) documents consist of: ▪ Annual Notice of Change ▪ Summary of Benefits ▪ Provider Directory Insert ▪ Notice of Privacy Practices ▪ Non-Discrimination Insert	• Annually	• CalOptima continues to consistently meet this requirement

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C&L Goals and Objectives

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Cultural and Linguistic Services
2018 Goals and Objectives

VI. Interpretative Services	• Comply and adhere to regulatory requirements to provide culturally and linguistically appropriate services to Members • Provide, at no-cost to the Member, twenty-four (24) hour access to interpreter services at Key Points of Contact	• CalOptima provides at no cost to the Member, twenty-four (24)-hour access to interpreter services at Key Points of Contact. Such services include: ▪ Linguistic interpreter services, American Sign Language (ASL) interpreter services, and information about the California Relay • Service (CRS) to members with hearing or speech impairments, and auxiliary aids for Members with visual impairments, as necessary. • CalOptima informs Members of the no cost interpreter services through the CalOptima Member Handbook, Customer Service and other communications, including, but not limited to posters and flyers distributed at sites where Members receive Covered Services, Member Newsletters, New Member orientation sessions. • In addition to Face-to-Face interpreting, CalOptima utilizes a vendor for telephonic and video interpreting services for Urgent Care and Emergency Services or as needed at Key Points of Contact.	• Daily	• Year-to-Date (YTD) 2018 C&L has received 1,788 Face to Face interpreter requests. which have been successfully booked and completed: ▪ Quarter 1 – 385 Requests ▪ Quarter 2 – 799 Requests ▪ Quarter 3 – 604 Requests ▪ Quarter 4 – TBD • As of Q3 2018 C&L has not received any video interpreting requests

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Cultural & Linguistic Team

Contact C&L Services: culturallinguistic@caloptima.org

- Carlos Soto, Manager
- Translations Team
  - Fabiola Benitez (Spanish)
  - Maria Oseguera (Spanish)
  - Treyna Trans (Vietnamese)
  - Samira Zahedi (Farsi)
  - Shannon Jun (Korean)
  - Lu Valmidiano (Chinese)
  - Elizabeth Mikhail (Arabic)

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QUESTIONS?

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CalOptima's Mission

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

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