NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS'
ONECARE CONNECT CAL MEDICONNECT PLAN
(MEDICARE-MEDICAID PLAN)
MEMBER ADVISORY COMMITTEE

FEBRUARY 28, 2019
3:00 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 August 23, 2018 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC 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 PAC. 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.   CEO AND MANAGEMENT REPORTS
A. Chief Executive Officer (CEO) Update
B. Chief Medical Officer (CMO) Update
C. Federal and State Legislative Update

VII.   INFORMATION ITEMS
A. OneCare Connect Member Advisory Committee Member Updates
B. Opioid Crisis Update
C. Update on State Budget
D. Update on Dental Initiatives
E. Understanding Skilled Nursing in Today's Changing Health Care Environment

VIII.   COMMITTEE MEMBER COMMENTS

IX.   ADJOURNMENT

MINUTES

REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS'
ONECARE CONNECT
CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN)
MEMBER ADVISORY COMMITTEE

August 23, 2018

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on August 23, 2018 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Gio Corzo called the meeting to order at 3:01 p.m. and led the Pledge of Allegiance.

Chair Corzo welcomed Keiko Gamez as the Member/Family Member Representative.

ESTABLISH QUORUM
Members Present:	Gio Corzo, Chair; Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Keiko Gamez
Members Absent:	George Crits (non-voting), Erin Ulibarri (non-voting), Jyothi Atluri (non-voting), Richard Santana, Kristin Trom
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Dr. Emily Fonda, Medical Director, Medical Management; Betsy Ha, Executive Director, Quality Analytics; Albert Cardenas, Director, Customer Service (Medicare); Cheryl Simmons, Provider Relations; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the June 28, 2018 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

> *Action:*   *On motion of Member Sandy Finestone, seconded and carried, the Committee approved the minutes of the June 28, 2018 meeting. (Motion carried 8-0-0, voting members Santana and Trom absent.)*

PUBLIC COMMENT
There were no requests for public comment.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, noted that the National Committee for Quality Assurance (NCQA) conducted its tri-annual audit of CalOptima in July. The preliminary report indicates that CalOptima achieved a near perfect score, which will allow CalOptima to extend its accreditation. Mr. Schrader provided an update on the transition of the California Children's Services (CCS) to the Whole-Child Model (WCM) effective January 1, 2019, and an update on PACE Alternative Care Setting (ACS) sites located in Garden Grove and Laguna Woods. Additional ACS sites will open in the Fall in the cities of Anaheim and Santa Ana, and CalOptima anticipates that a fifth ACS site will open in 2019.

Chief Medical Officer (CMO) Update

Emily Fonda, M.D., Medical Director, provided an update on the PACE expansion transition to alternative care settings, and noted that. PACE members can keep their primary care physician (PCP) if the PCP chooses to participate in the PACE program.

Dr. Fonda reported on the Whole Person Care (WPC) program designed to increase access and help with navigation of services for the homeless. The program is a collaborative effort between CalOptima and the Orange County Health Care Agency (OCHCA). OCHCA also manages a recuperative care program, which has expanded to three facilities and has increased the maximum length of stay from 15 to 90 days as part of the WPC program. Several Committee members inquired about touring these recuperative care facilities. Staff will provide the members with available dates for tours of these facilities.

Dr. Fonda also noted that CalOptima's Long Term Services and Support (LTSS) Department will be collaborating the University of California Irvine (UCI) in developing the LTSS plan that would be instrumental in helping reduce admissions to the hospital.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Corzo reported that the Member Advisory Committee (MAC) is hosting a joint advisory committee meeting on November 8, 2018. Member Gamez volunteered to serve on an ad hoc committee with Chair Corzo to help develop the joint advisory committee meeting agenda with the ad hoc members from the other committees.

Vice Chair Mouton announced that the 29th Annual Alzheimer's Research Conference, in collaboration with Alzheimer's Orange County, the UCI Mind Institute, and The Pacific Hospice and Palliative Care Foundation, will be held on October 6, 2018 in Irvine.th. Vice Chair Mouton also noted that the California Conference of Catholic Bishops have embarked upon a Whole Person Care initiative to improve access and education on Palliative and Hospice Care, and a conference is scheduled at the Christ Cathedral campus in Orange on October 25, 2018.

Member Chigaros reported that Chief Medical Officer Michelle Eslami, M.D. is now with Rockport Healthcare Services. Dr. Eslami has agreed to present at a future OCC MAC meeting.

Intergovernmental Transfer (IGT) Funds 5, 6 &7 Update
Cheryl Meronk, Director, Strategic Planning, provided an overview of the approved Intergovernmental Transfer (IGT) Funds for IGT 5, 6 and 7. IGT 5 has $14.4 million available for community grants, and eight Requests for Information (RFI) generated 93 responses. Staff is currently reviewing these responses and recommendations regarding the proposals will be presented for consideration at a future Board meeting. CalOptima received an additional $8 million of unanticipated funds related to IGT 6 and 7. On August 2, 2018, the Board approved an allocation of $10 million in IGT funds from IGT 6 and 7 to the OCHCA for recuperative care services under the Whole-Person Care pilot program. A recommendation for expenditure plans for the remaining $21.1 million will be presented to the Board for consideration in September.

Health Homes Program (HHP) Update
Candice Gomez, Executive Director, Program Implementation reported that HHP was authorized at the Federal level through Affordable Care Act (ACA) and is available for eligible members in CalOptima's OneCare and OneCare Connect programs. The HHP program is scheduled to take effect July 1, 2019.

Annual Healthcare Effectiveness Data and Information Set (HEDIS) Update and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Update
Irma Munoz, Lead Project Manager, Quality Analytics, and Marsha Choo, Manager, Quality Analytics, presented the 2018 HEDIS and CAHPS results, and reported that CalOptima improved its performance levels from the previous year.

ADJOURNMENT
Chair Corzo announced that the next OCC MAC Meeting will be held on Thursday, October 25, 2018.

Hearing no further business, the meeting adjourned at 4:27 p.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: February 28, 2019

M E M O R A N D U M

DATE:	February 7, 2019
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; and Whole-Child Model Family Advisory Committee

Whole-Child Model (WCM) Provider Network Gains Preliminary Approval
Great news! CalOptima received preliminary approval of our WCM provider network. This success is a testament to CalOptima staff and leaders at our delegated networks who responded quickly and effectively to comply with the revised network adequacy standards released by the Department of Health Care Services (DHCS) in November. CalOptima will be submitting contract signature pages by March 1, and DHCS has stated that it will provide final approval of the networks' participation by March 15. To keep stakeholders informed about our ongoing progress toward WCM implementation on July 1, CalOptima held two special meetings with the Provider Advisory Committee and the WCM Family Advisory Committee.

CalOptima Featured in Be Well OC Regional Mental Health and Wellness Campus Debut
On January 29, Orange County learned about the public-private partnership focused on changing our community's mental health system of care. The County of Orange approved a $16.6 million investment in the Be Well OC Regional Mental Health and Wellness Campus. This joins CalOptima's commitment of $11.4 million for services in the new facility as well as $12 million from Kaiser and St. Joseph Hoag Health. The campus aspires to create a new approach to mental health care that brings together a range of services from prevention and early intervention to acute care and recovery. Construction of the 60,000-square-foot facility begins in the spring. CalOptima participated in the initial press conference announcing the campus, and we anticipate further coverage as news of this first-of-its-kind facility travels.

Supervisor Doug Chaffee Appointed as Alternate CalOptima Board Member
As the new supervisor for Orange County's Fourth District, Doug Chaffee was appointed by Chairwoman Lisa Bartlett to serve as the alternate on CalOptima's Board of Directors, effective January 29. Bartlett also reappointed Supervisors Andrew Do and Michelle Steel as CalOptima Board members. Prior to Supervisor Chaffee's appointment, I met with him to share an overview of CalOptima, including our history, membership and programs. Supervisor Chaffee expressed his appreciation for CalOptima's service to the 180,000 members in his district.

California Governor Sets Out Ambitious Health Care Platform
Gov. Gavin Newsom began his term on January 7, and right away, he made it clear that health care would be a central focus of his administration's agenda. He announced a plan to expand Medi-Cal to cover undocumented young adults, proposed a statewide individual health insurance

mandate and issued an executive order to consolidate pharmacy purchasing to lower drug costs. As you know, he campaigned on a universal health care platform, so his proposals signal he intends to work diligently toward changes that address gaps in coverage, access and cost. Given the scope and significance of the governor's early effort, CalOptima is planning on extensive advocacy work alongside our associations to ensure the interests of our members are considered.

Proposed State Budget Signals Changes in Health Care Landscape
On January 10, Gov. Newsom released his FY 2019–20 state budget proposal, which provides additional detail regarding his ambitious health policy agenda. One of the most impactful elements of this agenda is the carve-out of prescription drugs from Medi-Cal managed care and the return of this benefit to a fee-for-service model no sooner than January 1, 2021, as part of an overall plan to boost the state's negotiating power with pharmaceutical companies. Despite the information in the budget proposal, many aspects of this transition are yet to be defined, and we plan to engage our associations to influence this potentially major change. Separately, regarding the proposed expansion of Medi-Cal to approximately 138,000 undocumented individuals ages 19 through 25, the budget includes the expected cost of $260 million in FY 2019–20. Further, the budget proposes to maintain existing Prop. 56 supplemental payments to providers and create new programs funded by these revenues, which total $3.2 billion for FY 2019–20. One new Prop. 56 program would establish incentives for providers to increase or improve services in high-impact areas, such as behavioral health, prenatal/postpartum care or chronic disease management. Both the expansion of Medi-Cal and the Prop. 56 changes would require legislation to implement. Further, these changes are predicated on the new administration's expectation that the state's economy will experience moderate growth in the next fiscal year. The governor's May Revise could include adjustments based on an updated economic outlook or potential federal policy changes.

Texas Affordable Care Act (ACA) Ruling Raises Questions About Stability of the Law
As was widely reported, a federal judge in Texas issued a ruling in December that could impact the future of the ACA. Specifically, he found that the ACA is unconstitutional based on the removal of the individual mandate tax penalty. The ACA drove the expansion of Medi-Cal and thus CalOptima's growth in membership since 2014. That said, the ruling is far from final, and government officials and legal experts expect an appeal will likely reach the U.S. Supreme Court. Until appeals are resolved, the Texas judge granted a stay, so the law is unchanged for our Medi-Cal expansion members. CalOptima will advocate through our state and national trade associations to ensure the stability of the ACA.

Homeless Health Is the Central Topic of Meetings With County Leaders
In January, CalOptima participated in key meetings addressing homeless health:
- Judge David O. Carter: Supervisor Andrew Do, Orange County Health Care Agency Director Richard Sanchez and I met with Judge Carter to discuss CalOptima's activities in homeless health given Orange County's ongoing homeless crisis.
- County Agencies: CalOptima and county leaders, including representatives from the Health Care Agency, Social Services Agency and Office of Care Coordination, met twice in January to tackle issues related to improving services for our community's homeless population. The first meeting clarified the resources available from the county and CalOptima. The second meeting focused on how to deliver physical health to homeless individuals where they are.

As a result of the meetings with the county and the judge, staff are developing proposals in collaboration with stakeholders to address the gaps in the system that separate members who are homeless from the health care they need. While the current delivery system does not work for them, there is no single alternative solution. Thus, CalOptima is exploring a flexible, multipronged approach. Our proposals center on enhanced same-day transportation, increased use of mobile clinics at shelters and clinical field teams that deliver care on the street when necessary. An Information Item at your Board meeting this month will provide additional details.

CalOptima Requests Flexibility in Start Date for Health Homes Program (HHP)
HHP is designed to serve Medi-Cal members with multiple chronic conditions who may benefit from enhanced care management and coordination. At this time, CalOptima is slated to participate in the HHP starting July 1, 2019, which is the same go-live date as the WCM transition. Our regulatory team recently asked DHCS officials if there is any flexibility around that date due to the overlap and associated demands on staff and health networks. Additionally, DHCS provided guidance requiring modifications to our proposed approach to HHP using the delegated model. CalOptima expects feedback on the issue of timing and our HHP model during an upcoming conference call with the state.

Opioid Epidemic Update

OneCare Connect Member Advisory Committee

February 28, 2019

Kris Gericke, Pharm.D.

Director, Pharmacy Management

Opioid Epidemic

- Drug overdose is the leading cause of unintentional death in the United States, causing more deaths than motor vehicle accidents.
- Of the more than 70,200 drug overdose deaths in 2017, 68% involved an opioid.
- The most common drugs involved in prescription opioid overdose deaths include:
  - Methadone
  - Oxycodone (such as OxyContin®)
  - Hydrocodone (such as Vicodin®)
- Prescription opioid overdose deaths also often involve benzodiazepines such as:
  - Alprazolam (Xanax®)
  - Diazepam (Valium®)
  - Lorazepam (Ativan®)

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Impact On Medicaid

- Inappropriate prescribing practices and opioid prescribing rates are substantially higher among Medicaid patients than among privately insured patients

- In one study based on 2010 data, 40% of Medicaid enrollees with prescriptions for pain relievers had at least one indicator of potentially inappropriate use or prescribing:
  - ➤ Overlapping prescriptions for pain relievers
  - ➤ Overlapping pain reliever and benzodiazepine prescriptions
  - ➤ Long-acting or extended release prescription pain relievers for acute pain, and
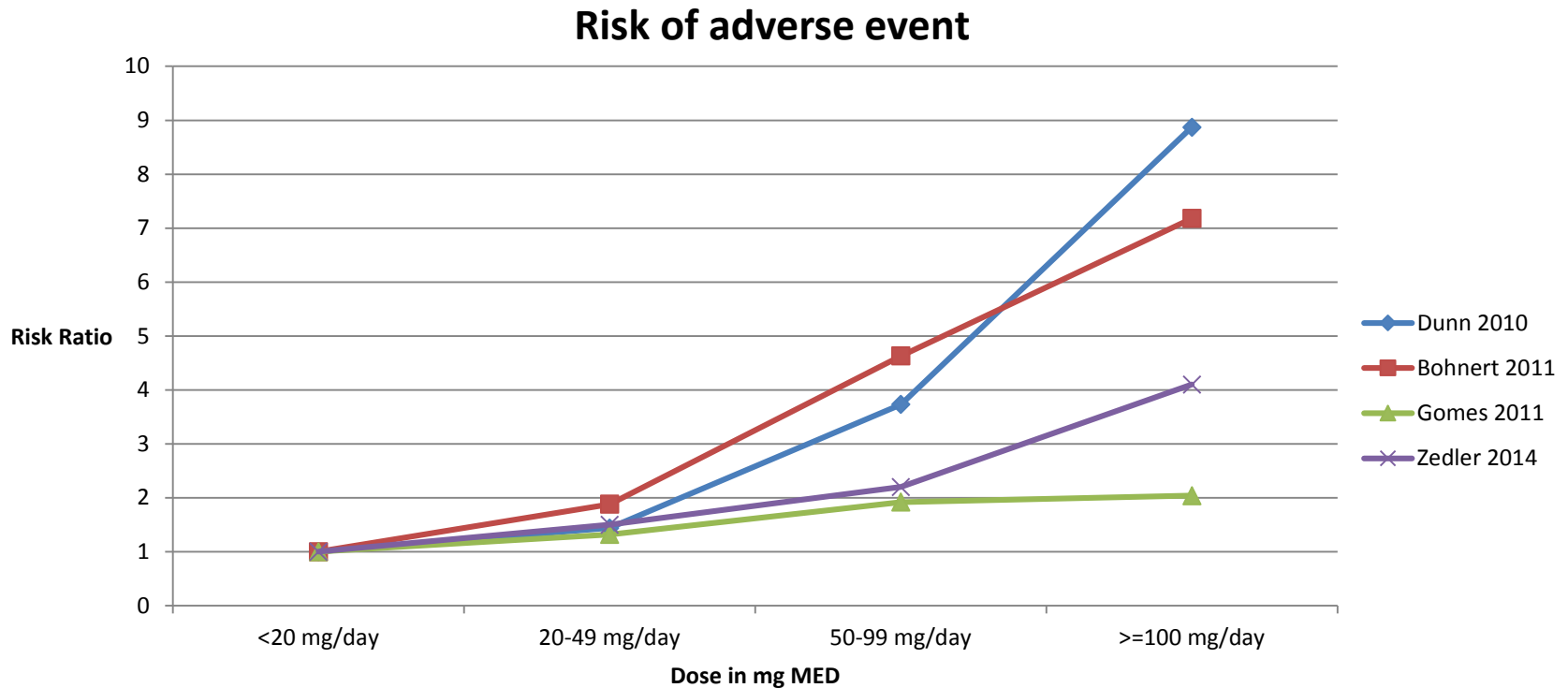 - ➤ High daily opioid doses

Orange County Opioid Statistics
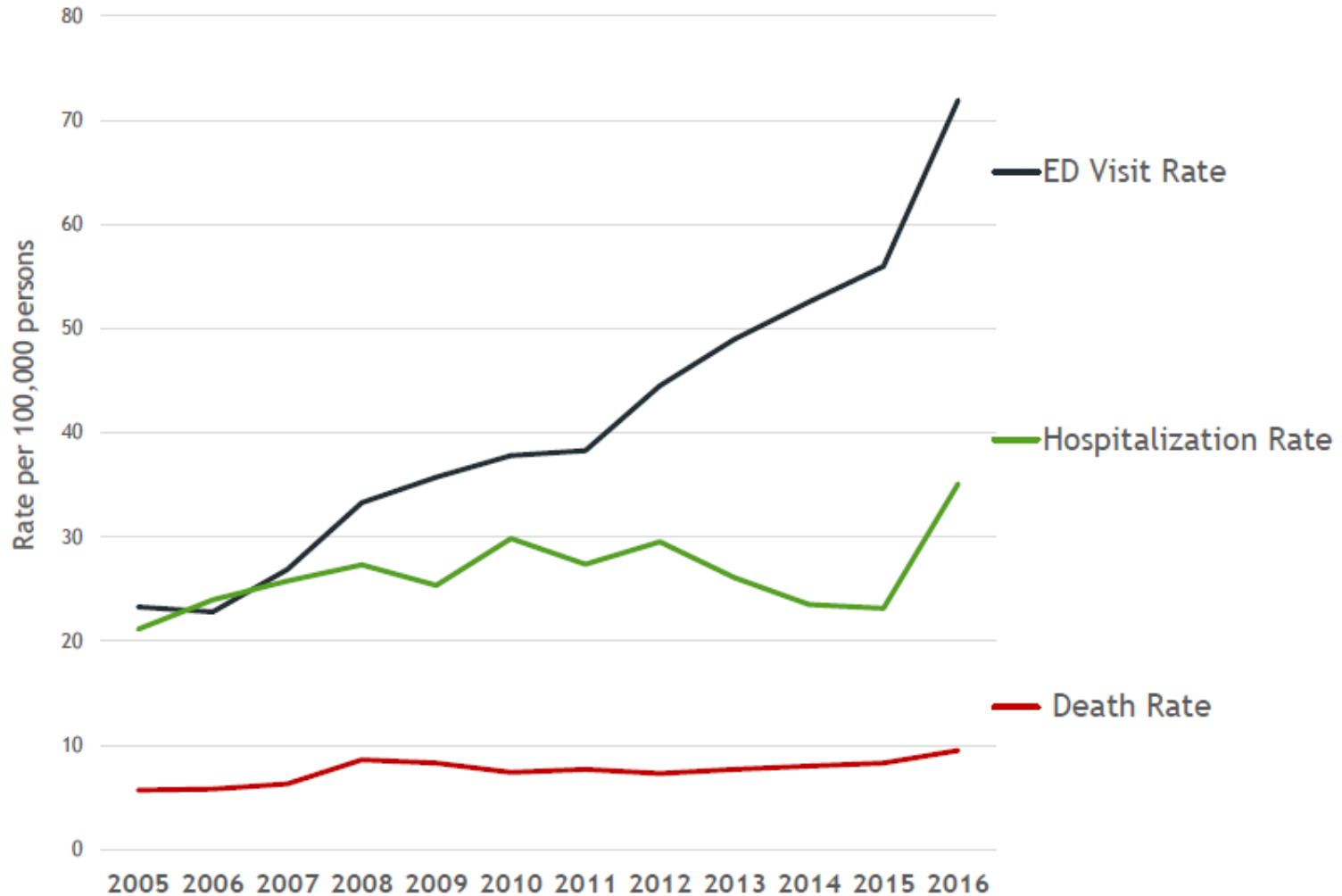
Opioid Overdose Death Rates

5
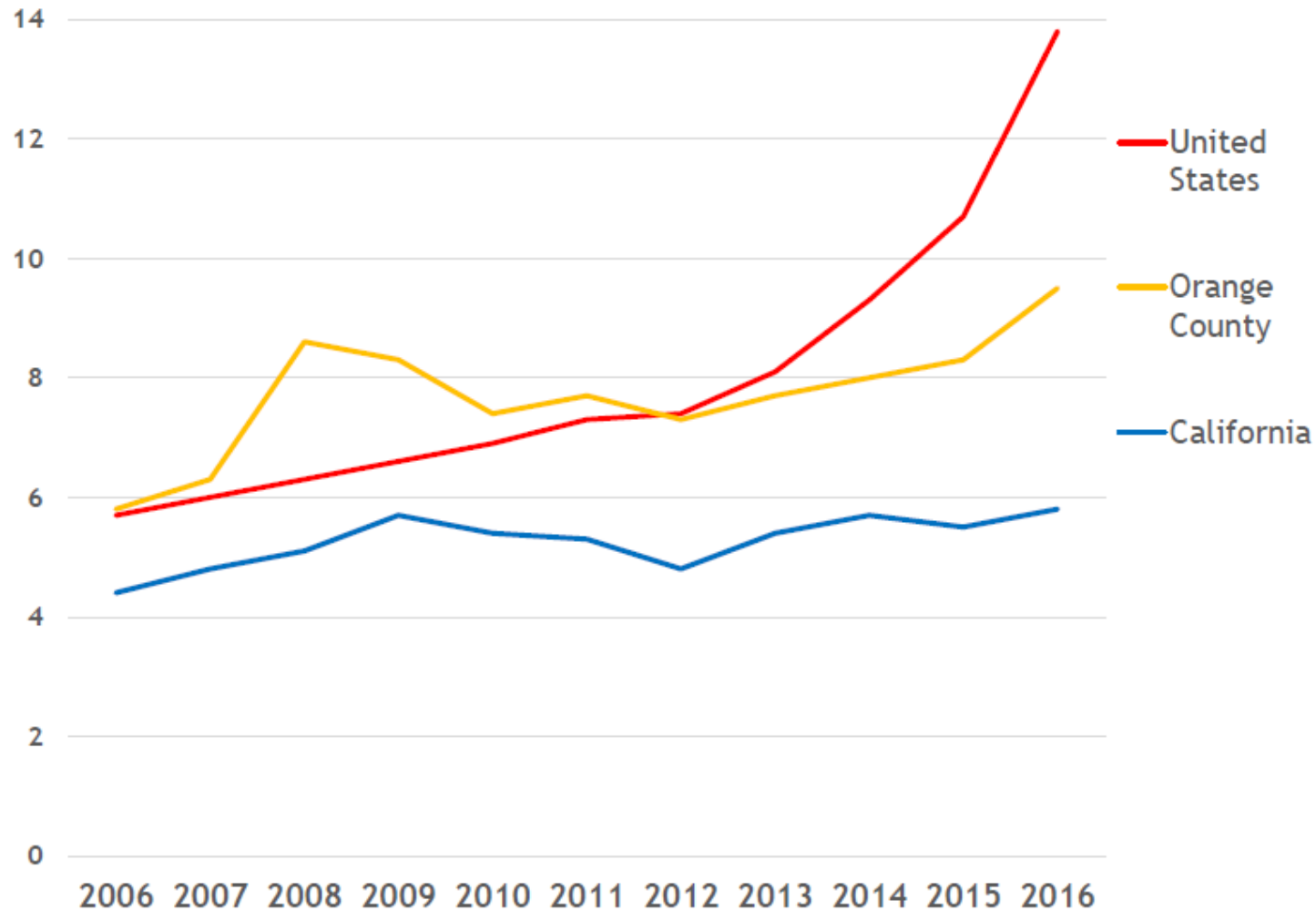
Opioid Dose-Related Risk

Risk of adverse event
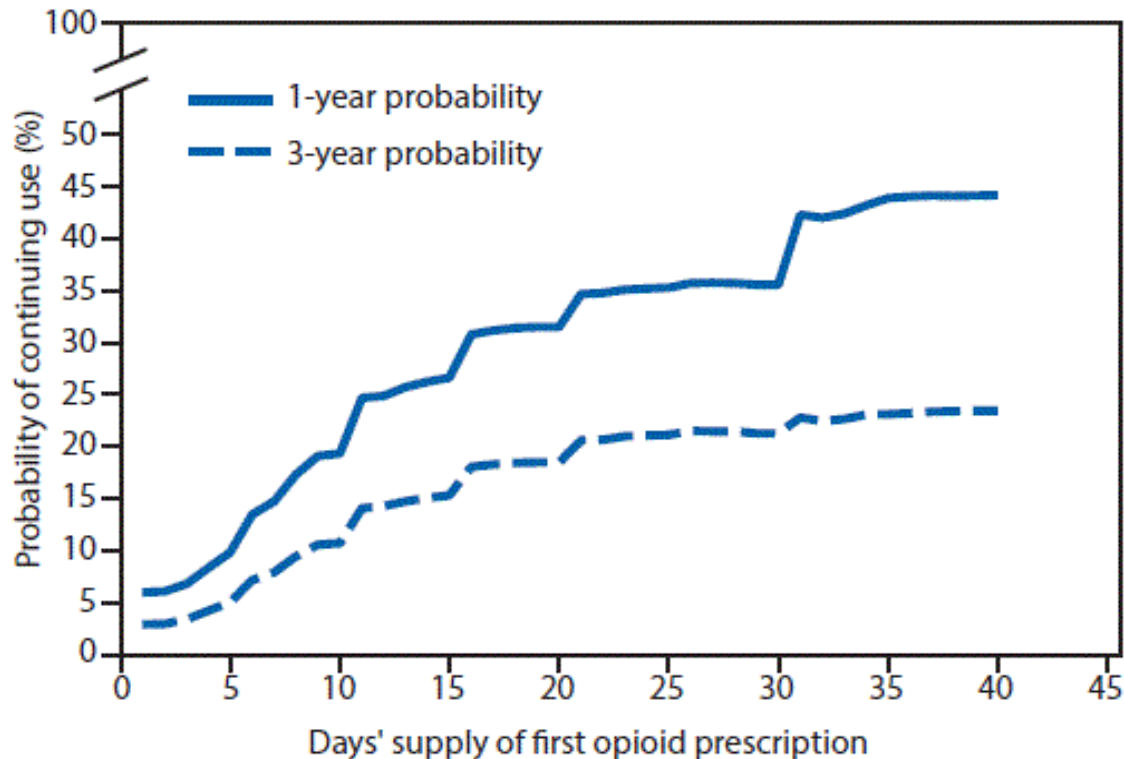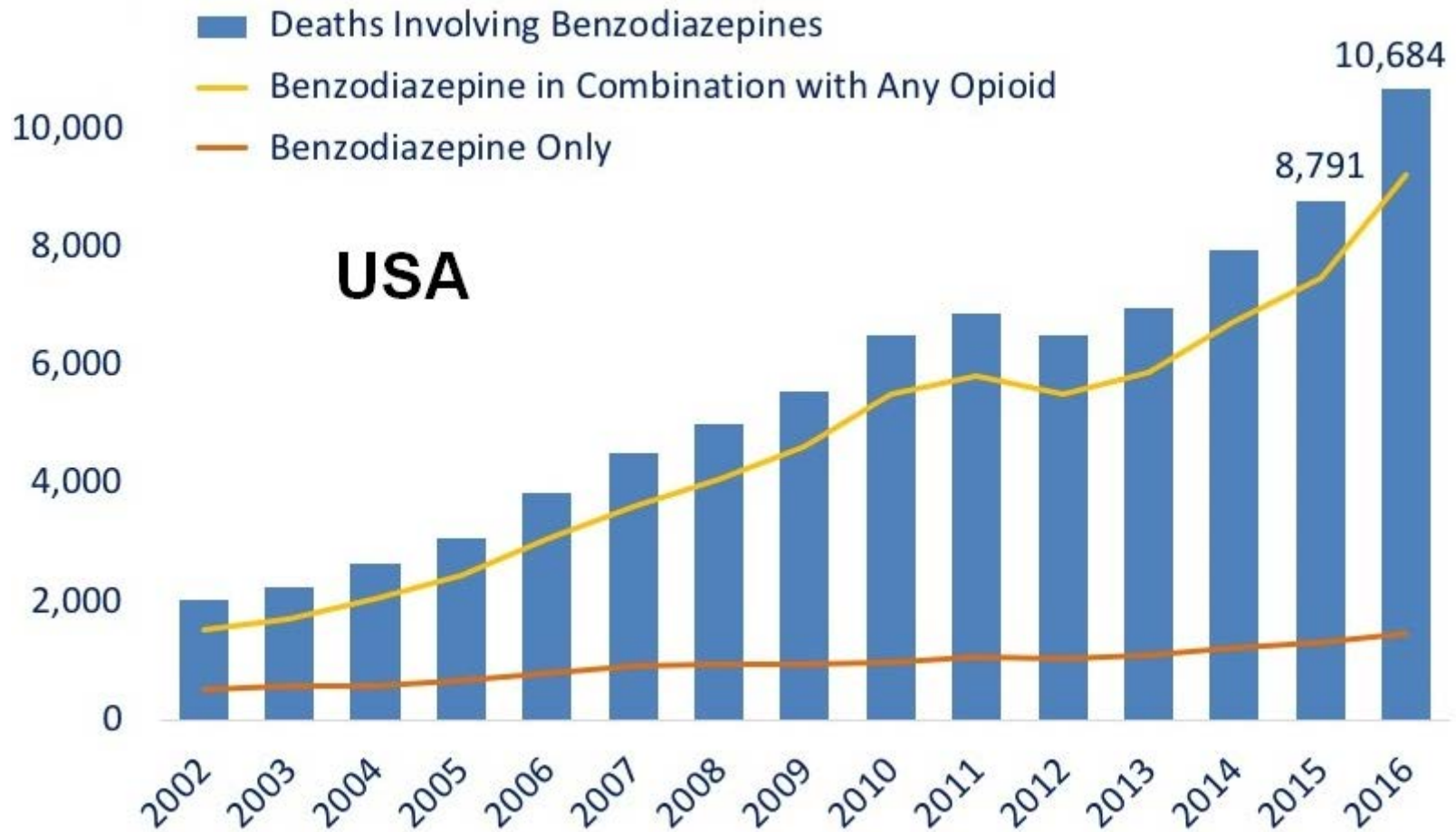
Two thirds of those using opioid medications for 90 days continue to use them long term (>2 years)

Opioid Addiction Risk For New Prescriptions

Opioids And Benzodiazepines

Source: National Center for Health Statistics, CDC Wonder

CalOptima Opioid Interventions

- Formulary restriction
  - Require prior authorization for new starts of drugs with the highest risk of overdose
    - Methadone
    - Extended-release high-dose morphine
  - Require prior authorization for short-acting opioid analgesic combinations exceeding formulary quantity limits
- Drug utilization review (DUR) point-of-service pharmacy edits
  - Cumulative morphine milligram equivalent (MME) pharmacy edits
    - 90 MME pharmacy edit overridable by the dispensing pharmacy (soft edit)
    - 200 MME pharmacy edit non-overridable by the dispensing pharmacy (hard edit) OC/OCC
    - 400 MME pharmacy edit non-overridable by the dispensing pharmacy (hard edit) Medi-Cal

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CalOptima Opioid Interventions (cont.)

- Drug utilization review (DUR) point-of-service pharmacy edits (cont.)
  - ➤ Concomitant opioid analgesic/benzodiazepine pharmacy edit overridable by the dispensing pharmacy (soft edit)
- Member interventions
  - ➤ Pharmacy Home Program: CalOptima Medi-Cal members filling prescriptions at four or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year
  - ➤ Provider Restriction Program: Members that have filled controlled substance prescriptions from four or more prescribers in a two-month period: Prior authorization required for controlled substance prescriptions not written by the member's designated prescriber
  - ➤ Case Management and opioid interdisciplinary care team

CalOptima Opioid Interventions (cont.)

- Prescriber interventions
  - High volume/high MME prescriber quarterly report cards
  - Education programs
- Quality initiatives
  - Retrospective identification of opioid overutilization for Medical Director review
  - HEDIS and CMS Star measures

CalOptima Opioid Utilization

% of Members Utilizing Opioid Analgesics

CalOptima Opioid Utilization (cont.)

% Utilizing Members Over 80mg Avg MME

13
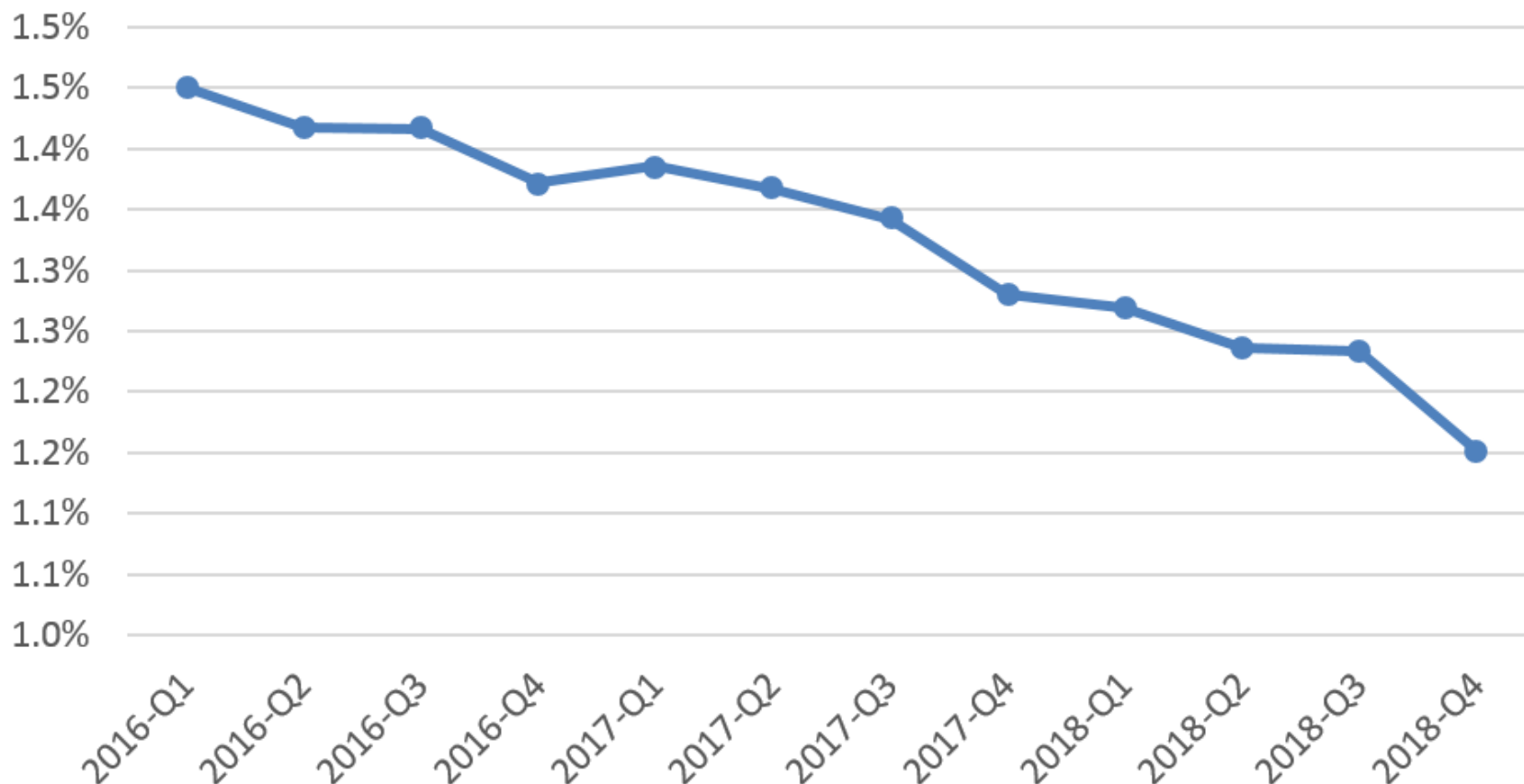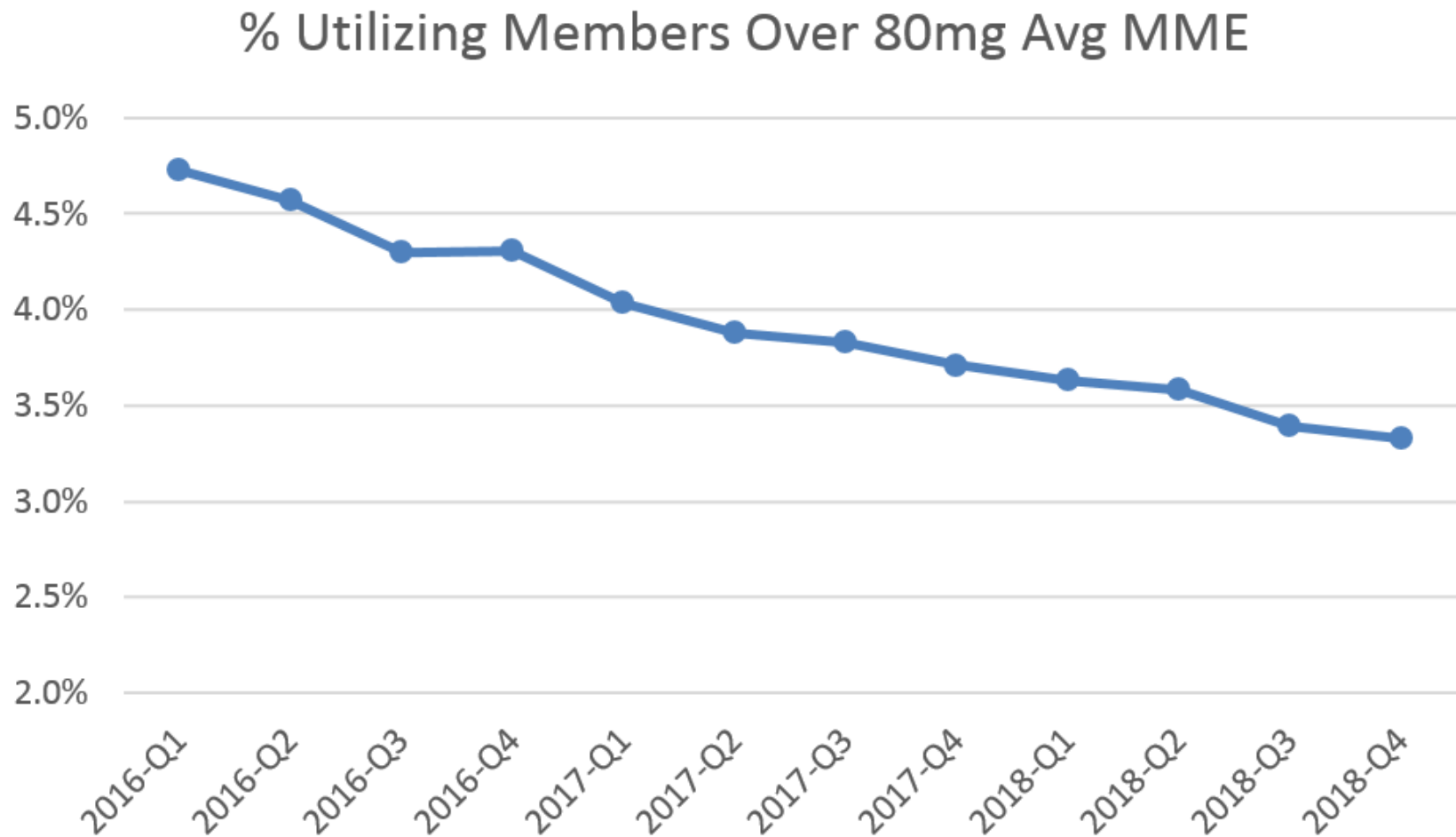
CalOptima Opioid Utilization (cont.)

Substance Use Disorders: All LOB	2018-Q1	2018-Q2	2018-Q3	2018-Q4
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.7	16.9
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521

What Else Can Be Done?

- Improve opioid prescribing
  - CDC's Guideline for Prescribing Opioids for Chronic Pain
  - CURES monitoring requirement
- Prevent opioid use disorders
  - Facilitating conversations with patients about the risks and benefits of pain treatment options
  - Patient education, including the safe storage and disposal of prescription opioids

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What Else Can Be Done?

- Treat opioid use disorders
  - Medication Assisted Treatment (MAT)
    - Buprenorphine (Suboxone)
    - Naltrexone (Vivitrol)
    - Methadone
  - Counseling and behavioral therapies
- Reverse overdose to prevent death: Expand access to Naloxone (Narcan)

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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California State Budget: FY 2019–20 Proposal

OneCare Connect Member Advisory Committee

February 28, 2019

Arif Shaikh

Director, Public Policy and Government Affairs

California Budget Overview

- Fiscal Year (FY) 2019–20
- Total Proposed Budget = $209 billion
- General Fund = $144 billion
- Budget Surplus = Approximately $20 billion

Proposed Medi-Cal Budget

- Estimated enrollment of 13.2 million members

FY 2019–20 Proposed Medi-Cal Budget	
General Fund	$22.9 billion
Federal Funds	$62.7 billion
Other	$15.1 billion
Total	**$100.7 billion**

Funding Shares

- Medi-Cal Classic = 50/50 federal/state

- Medi-Cal Expansion
  - 2019 = 93/7 federal/state
  - 2020 = 90/10 federal/state

- Children's Health Insurance Program (CHIP) = 88/12 federal/state

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Pharmacy Services Carve-Out

- Executive Order: Carve out pharmacy services from Medi-Cal managed care and return to fee-for-service
- No sooner than July 1, 2021
- Part of an effort to control drug costs
- Senate Budget Committee Informational Hearing on February 14, 2019

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Additional Prop. 56 Funding

- Maintain existing Prop. 56 supplemental payments to providers

- Create new Prop. 56 programs
  - Example: Incentives for providers to increase or improve services in high-impact areas, such as behavioral health integration, prenatal/postpartum care or chronic disease management
  - Requires trailer bill language to implement
  - Program details pending

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MCO Tax Sunset

- Budget proposal assumes the Managed Care Organization (MCO) Tax sunset on June 30, 2019
  - ➢ MCO Tax brought in approximately $1 billion/year for Medi-Cal

- Key legislators are interested in extending the MCO Tax
  - ➢ Sen. Richard Pan, Chair, Senate Health
  - ➢ Assemblyman Jim Wood, Chair, Assembly Health

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Expanding Full-Scope Medi-Cal

- Expand full-scope Medi-Cal to undocumented individuals up to age 25
- No sooner than July 1, 2019
- DHCS estimates:
  - 138,000 newly eligible individuals
  - $194 million General Fund cost in FY 2019–20
- AB 4/SB 29: Expand full-scope Medi-Cal to all undocumented individuals

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Next Steps

- Governor's January budget proposal is just the first step
- Legislature will now begin holding budget hearings
- Governor will release the May Revise
- Legislature then has until June 15 to pass a final state budget
- Governor has until June 30 to sign

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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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California State Budget: FY 2019-20 Proposal Analysis and CalOptima Impacts

January 2019

Overview

On January 10, 2019, Governor Gavin Newsom released his 2019-20 state budget proposal. The total budget proposed is $209 billion, with General Fund spending at $144 billion, which is flat compared to current year spending. The budget anticipates that the state's economy and associated revenues will grow at a modest rate, approximately 3.5 percent, which is lower than previous expectations, but still enough to drive an ambitious policy agenda.

Specific to health policy, Gov. Newsom put forward major changes soon after his inauguration on January 7. He announced a plan to expand Medi-Cal to cover undocumented young adults, proposed a statewide individual health insurance mandate and issued an Executive Order to consolidate pharmacy purchasing in order to lower drug costs. He also sent a letter to Congress and the Administration requesting that the Federal Government grant California the regulatory and statutory flexibility required to implement a single-payer system, stating that it does not have the latitude to do so under current law.[1] The budget proposal provides additional detail regarding some of these potential changes.

The Medi-Cal Budget

The increase in General Fund dollars allocated to Medi-Cal funding (see table 1 below) is based on an estimated Medi-Cal enrollment of 13.2 million members in fiscal year (FY) 2019-20.[2]

FY 2019–20 Proposed Medi-Cal Budget[3]

General Fund	$22.9 billion (10.6 percent increase from 2018-19)
Federal Funds	$62.7 billion (includes $19.9 billion for MCE)[4]
Other	$15.1 billion (includes $1.05 million in Prop. 56 funds)[5]
Total	**$100.8 billion**

Please note that the federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as Medi-Cal classic, there is a 50/50 match. For the Medi-Cal expansion (MCE) population,

there is an enhanced federal match (93/7 for calendar year 2019 and 90/10 for calendar year 2020).[6] For the Children's Health Insurance Program (CHIP) population, there is currently an 88/12 match.

Additional Proposition 56 Medi-Cal Funding

The "other" portion of the Medi-Cal budget, by and large, accounts for state dollars that are drawn from the special funds pool, which includes, for instance, tobacco tax revenue designated for Medi-Cal. A large portion of the revenue raised by Prop. 56's expansion of the tobacco tax, approved by California voters in November 2016, is designated for augmenting the state's Medi-Cal budget through supplemental payments for physicians and dentists, among other health care related expenditures. The budget proposes to maintain existing Prop. 56 supplemental payments to providers and create new programs funded by these revenues, which, including federal matching dollars, totals $3.2 billion for FY 2019–20. One new Prop. 56 program would establish incentives for providers to increase or improve services in high-impact areas, such as behavioral health integration, prenatal/postpartum care or chronic disease management.

Pharmacy Services Carve-Out

One of the most impactful elements of Gov. Newsom's health policy agenda is the carve-out of prescription drugs from Medi-Cal managed care and the return of this benefit to fee-for-service (FFS), no sooner than January 1, 2021.[7] While some additional information about this transition was in the budget proposal, many aspects are yet to be defined. The governor's Executive Order (N-01-19), announced immediately after his inauguration, requires the Department of Health Care Services (DHCS) to begin planning for the transition to FFS in order to boost the state's negotiating power with pharmaceutical companies. This is part of the governor's effort to address the rapidly rising cost of prescription drugs. However, numerous questions remain, including whether the state can strengthen its ability to negotiate more effectively with drug companies without a total carve-out of the pharmacy benefit. Carving pharmacy services out of Medi-Cal managed care is likely to result in serious unintended consequences, such as reduced care coordination,

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inefficient drug utilization and a far greater administrative burden on the state. Given these considerable concerns, health plans are working with the Newsom Administration on this issue to point out potential challenges as well as suggest alternate solutions, while still supporting his overall goal of controlling pharmaceutical costs and increasing health care affordability.

Expanding Full-Scope Medi-Cal

The Budget proposal includes a provision to expand full-scope Medi-Cal to undocumented individuals between the ages of 19 to 25, no sooner than July 1, 2019.[8] According to DHCS, by the end of the first year of implementation, this expansion would result in an estimated 138,000 newly eligible individuals receiving full-scope benefits at a cost of $194 million to the state's General Fund ($260 million total). Of note, two companion bills were recently introduced in the legislature – Assembly Bill (AB) 4 and Senate Bill (SB) 29 – that would expand full-scope Medi-Cal to cover undocumented individuals regardless of age. Analyses of AB 4/SB 29's enrollment and fiscal impacts are not currently available, but are likely to be produced as these bills proceed through the legislative process.

Managed Care Organizations (MCO) Tax

Also of note, the budget proposal assumes the sunset of the MCO Tax.[9] The MCO Tax is one of the financing mechanisms that the State of California utilizes to obtain increased federal funding to support the Medi-Cal program. The current iteration of the MCO tax, which became effective in July 2016 via a Centers for Medicare & Medicaid Services (CMS) waiver process, will sunset on June 30, 2019. Extending it would require reauthorization from the State Legislature and approval from CMS.[10] The health insurance industry in California has supported participation in the MCO tax, as it has resulted in substantial revenue streams for health care programs. Specifically, the MCO tax results in more than $1 billion in annual funding for the Medi-Cal program, as well as $300 million in funding to support services for people with developmental disabilities. Notably, there were

complexities associated with enacting the current MCO tax, as CMS required that it must meet new criteria, based on Medicaid financing provisions in the Social Security Act. Our state trade associations, California Association of Health Plans (CAHP), and Local Health Plans of California (LHPC) have begun discussions with key stakeholders, including legislators and state officials, to look at options for a potential renewal of the MCO tax, taking into account the criteria that was used to ensure the passage of its current iteration. Of note, Senator Richard Pan, Chair of the Senate Health Committee, Assembly Member Jim Wood, Chair of the Assembly Committee on Health, and officials from the state Department of Finance have all recently indicated their willingness to consider a MCO tax extension.[11]

Next Steps

Many of these policy changes are predicated on the new administration's expectation that the state's economy will experience moderate growth in the next fiscal year. The Governor's May Revise of the budget proposal could include adjustments based on a revised economic outlook or potential federal policy changes. We will continue to follow these proposals closely as they move through the budget process. Also, both the expansion of full-scope Medi-Cal and the Prop. 56 changes would require legislation to implement. Specific to the expansion, DHCS will propose trailer bill language to implement this change and it is likely to be dependent on systems changes and network readiness approvals being in place prior to implementation.

It is important to remember that the Governor's January budget proposal is just the first step in the state's budget process. The Legislature will now begin holding budget hearings in an effort to build consensus. After the Governor releases the May Revise, the Legislature will have until June 15 to submit a final state budget for the Governor's approval. CalOptima will continue to closely follow these ongoing budget discussions and provide updates regarding any 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. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

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Endnotes

[1] The Governor's Letter to Congress and the Administration is available at: https://www.gov.ca.gov/wp-content/uploads/2019/01/1.7.19-Letter-to-the-White-House-and-Congress.pdf

[2] Governor's Budget Summary 2019-20, p. 62

[3] Department of Health Care Services, "2019-20 Governor's Budget Highlights," p. 14

[4] Governor's Budget Summary 2019-20, p. 67

[5] Ibid

[6] Chernew, Michael. "The Economics of Medicaid Expansion," Health Affairs Blog, available at: https://www.healthaffairs.org/do/10.1377/hblog20160321.054035/full/

[7] Department of Health Care Services, "2019-20 Governor's Budget Highlights," p. 6

[8] Governor's Budget Summary 2019-20, p. 65

[9] Ibid, p. 70

[10] Legislative Analyst's Office, "The 2019-20 Budget: Overview of the Governor's Budget," p. 12

[11] "California Should Extend Tax on Managed Care Organizations, Lawmakers Say," Politico Pro California, February 12, 2019, available at: https://subscriber.politicopro.com/states/california/story/2019/02/12/california-should-extend-tax-on-managed-care-organizations-lawmakers-say-851571

Understanding Health Plans' Role in Pharmacy Benefit Delivery

California Association of Health Plans

Prescription drug benefits are an integral part of Medi-Cal managed care. Integrating the pharmacy benefit alongside medical care, behavioral health, and other services allows Medi-Cal plans to provide a comprehensive person-centered approach — which allows plans to work with providers to emphasize clinically effective, evidence-based treatments that provide an important window into all the care elements that impact a person's health. Knowing a person's prescription drug history is critically important in order to avoid harmful drug interactions and medication related errors.

The Medi-Cal Managed Care Pharmacy Benefit
A Comprehensive Approach to Care

QUALITY

- High quality and efficiency standards
- Regular review of drug formularies by clinical experts to promote safe & effective use of medications
- Rigorous quality improvement and compliance programs

ACCESS

- Access to a network of thousands of retail and community pharmacies and a single point of customer care.
- 24 hour call centers and processing units

CHOICE

- Medi-Cal managed care plans oversee a large list of prescription drugs, known as a formulary, which allows them to offer an extensive variety of treatments and therapies.

CARE COORDINATION

- **Care teams** of community physicians and pharmacists with expertise in determining the best care for Medi-Cal populations so prescription history is known to:

  - Avoid harmful drug interactions and medication-related errors.
  - Monitor opioid prescriptions to help prevent opioid misuse.
  - Avoid unnecessary use of emergency departments and hospitalizations.
  - Ensure that patients take their medications for chronic medical conditions according to how they were prescribed.
  - Reconcile medications by comparing what has been prescribed to what a member is already taking at home

- **Real time pharmacy data** – used to understand the needs of members enrolled in care coordination programs and develop drug therapies to complement:

  - **Chronic disease management** for conditions such as Diabetes, Asthma, Cardiac illness, Alzheimers, HIV/AIDS and many other complex health conditions.
  - **Whole Person Care and Health Homes** which target fragile populations experiencing homelessness, mental illness, and substance abuse disorder.

The Medi-Cal Managed Care Pharmacy Benefit
Real-World Stories

Health Plan Access to Pharmacy Data Critical in Times of Crisis

In a county served by a Medi-Cal managed care plan, a recent flashflood displaced residents from a local homeless shelter and contaminated their medications. Real-time pharmacy data enabled the plan to identify displaced members who were at risk of being unable to take their daily prescriptions and who faced potential medical crises as a result. This in turn informed where and how the health plan was able to dispatch caseworkers to locate and help these members gain access to their life-saving medications.

Whole Person Care Program Pharmacy Benefit Helping the Homeless, Saving Lives

One county in California with a "Whole Person Care (WPC) Program" partners with health plans and focuses in part on providing care to the homeless. When a health plan nurse with the WPC program discovered a 67-year-old man who was living in his car she found he was storing dozens of medications that were prescribed in the emergency room where he went routinely for care. WPC staff examined and interviewed him and worked with his newly established doctor who determined that although he had been prescribed 40 medications, he only needed less than 15 to treat his multiple illnesses which included congestive heart failure, COPD, and diabetes. The Whole Person Care program, which is only available through Medi-Cal managed care, likely saved this man's life.

The Medi-Cal Managed Care Pharmacy Benefit Saves Taxpayer Dollars

MEDI-CAL MANAGED CARE PLANS:

- Overseeing the pharmacy benefit are proven to outperform traditional fee-for-service programs when it comes to the total cost of care, patient experience, and health outcomes.

- Promote the use of therapeutically equivalent generic drugs and equally effective lower cost alternatives to ensure the pharmacy benefit and Medi-Cal program are affordable for the State of California.

- Promote the use of generic drugs which helps to reduce overall pharmacy costs when compared to brand named drugs.

Denti-Cal Initiative

OneCare Connect Member Advisory Committee

February 28, 2019

Arif Shaikh

Director, Public Policy and Government Affairs

Agenda

- Background
- Opportunity
- Exploration
- Next Steps

Background

- The Department of Health Care Services (DHCS) is responsible for administrating dental benefits for Medi-Cal beneficiaries through a system separate ("carved out") from medical benefits

- Dental benefits are administered by Denti-Cal using two different models
  - Fee-for-Service (FFS): Beneficiaries receive dental services from any licensed Denti-Cal-enrolled provider who accepts Denti-Cal payments and agrees to see them
  - Dental Managed Care (DMC): Medi-Cal pays dental plans a set amount per member per month, and members are only allowed to receive services from providers within the plan's network

Background (Cont.)

- The Little Hoover Commission issued a scathing 2016 report about FFS Denti-Cal
  - Denti-Cal is "broken, bureaucratically rigid and unable to deliver the quality of dental care most other Californians enjoy."
  - Utilization of dental benefits for Medi-Cal members is low, due primarily to a shortage of dental providers who participate in Denti-Cal

Background (Cont.)

- Currently, two California counties have DMC
  - Sacramento County: DMC model is mandatory, and Medi-Cal beneficiaries are mandatorily enrolled in a DMC plan Beneficiaries, however, may opt out of a DMC plan and move to a FFS Denti-Cal plan
  - Los Angeles County: Beneficiaries are automatically enrolled in FFS Denti-Cal and must opt in to participate in a DMC plan

- San Mateo County scheduled to launch DMC in July 2019
  - Gov. Brown signed State Bill 849 on June 27, 2018, authorizing a dental integration pilot program with Health Plan of San Mateo
  - Pilot is designed to test the impact on access, quality, utilization and cost when dental care is a managed care benefit

Opportunity

- CalOptima is committed to ensuring the health and well-being of our community
  - ➢ Track record of collaborating with providers, regulators and other stakeholders to improve the local delivery system
  - ➢ Ample experience at integrating programs and realizing better access and improved care coordination for members

- On November 1, 2018, CalOptima's Board of Directors authorized staff to explore policy opportunities to carve in dental benefits for Orange County Medi-Cal members

Exploration

- CalOptima staff will take a three-pronged approach to exploring the policy opportunity to carve in dental benefits
    1. Engage local stakeholders, including the Orange County Dental Society, to discuss opportunities for CalOptima to develop a dental provider network that increases access to dental care for Medi-Cal members
    2. Engage regulators and statewide advocacy organizations, including DHCS and the California Dental Association, to determine their level of support for policy solutions that integrate dental benefits into Medi-Cal managed care in Orange County
    3. Engage members of the Orange County delegation to identify opportunities through the state legislative process

Engage Local Stakeholders

- CalOptima is now working to gather feedback from local stakeholders who understand the needs of the community

- CalOptima will be seeking letters of support from organizations that share our interest in integration
  - Response is requested by March 1, so CalOptima can further discussions with regulators and state advocacy groups

Medi-Cal
CalOptima
A Public Agency
Better. Together.

CalOptima's Mission

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

The Current State of

Skilled Nursing Care

Prepared by: Michelle Eslami, MD FACP CMD   *Los Angeles, CA*

ROCKPORT
HEALTHCARE SERVICES

Nursing Homes in CA

1240 licensed facilities

- Almost 90% of nursing homes are privately owned

Caring for 370,000 pts

- Two populations
  - Skilled Nursing or (short-term)
  - Long Term Care

- 84% are discharged home w/in three months

Younger than you think

- 37% of residents are between 45 and 74 years old

▪ Rockport Healthcare Services ▪

ROCKPORT
HEALTHCARE SERVICES

Hidden **Population**

Only one in three older US adults has non-housing financial assets equivalent to one year of SNF care

Mostly covered by Medi-Cal

Urban campers and those who need assistance with Activities of Daily Living (ADLs)

Non-uniform

Medi-Cal reimbursement rates are not industry or region wide but facility specific

Costly residential care

Nursing home care costs CA $4.5 billion a year or about $76,000 per person

ROCKPORT
HEALTHCARE SERVICES

Comparing Nursing Homes

CMS rates nursing homes yearly on a five star scale based on health inspections, nurse staffing hours and Quality Measures	CA has a the most number of its high performing nursing homes in and around Sacramento	57% of all nursing homes have a four or five star CMS rating
CA has a larger share of highly rated nursing homes than the rest of the nation	Northern CA and the Sierra CA regions have the most poorly rated nursing homes	27% of all nursing homes have a one or two star CMS rating

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HEALTHCARE SERVICES

Staffing the Nursing Home

More LVNs & CNAs than RNs
One LVN to 30 patients; one RN to 50 patients;
3.5 nursing hrs PPD

High degree of staff turnover
70% of patient care performed by CNAs;
Low level of sophistication;

Good rehab services
Interdisciplinary approach to care

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HEALTHCARE SERVICES

SNF **Practice** Challenges

IT/eMR
Multiple systems that don't communicate; Costly to implement

MD presence
Required w/in 72 hrs of admission and as medically necessary

Diagnostics
No telemetry or EKG; labs and x-ray available on-site

Pharmacy
6-8 hours for delivery of meds for new admission

Utilization cost
Prospective Payment System (PPS) and Value Based Payments (VBP)

"More regulations than toxic waste"

Narcotics, psychoactive medications (previously physical restraints), infection prevention, antibiotic stewardship, use of Foley catheter, pressure sores, falls, medication reconciliation, patient centered care, dietary, activities, care planning …

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HEALTHCARE SERVICES

Rehospitalization Consequences

Value vs Volume

PAMA of 2014

Protecting Access to Medicare Act authorized SNF VBP

HOLDING 2% of all Medicare Payments

Incentives for low 30day all cause readmission rates

VBP started Oct 2018

Lookback period of Oct 2018; excludes planned readmissions

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HEALTHCARE SERVICES

Quality **Reporting** Program (**QRP**)

IMPACT Act of 2014

Crucial step forward for Medical modernization; affected all PAC sites

Included assessment domains:

- Functional
- cognitive
- Medical conditions and comorbidities

Quality Measures

- Skin integrity

- Function and cognitive status

- Medication reconciliation

- incidence of major falls

- Transfer of health information and care preferences

Resource Use

- Cost/beneficiary

- Discharge to community

- All condition, risk adjusted, preventable hospitalizations

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HEALTHCARE SERVICES

Mega Rule:

Requirements for Participation (RoP)for Long-Term Care Facilities (CMS-3260-F), 2016

First revision since OBRA in 1987

More than 700 pages

New guideline for surveyors

Updated F tags

Three phase of implementation

Phases 1 and 2: 2016 and 2017
Phase 3: November 2019

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HEALTHCARE SERVICES

Focus Areas for New RoPs

- Ensure proper training and competencies for dementia, elder abuse and person centered care
- Care Plans w/in 48hrs of admission
- Pharmacy and COC review
- QAPI (Quality Assurance/Performance Improvement)
- Infection prevention program w/ certified preventionist
- Antibiotic stewardship
- Payroll and Billing Journal (PBJ)

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HEALTHCARE SERVICES

Quality and Accountability Supplemental Payment (QASP) Program

- Pay-for-performance initiative for SNFs with Medi-Cal residents

- Quality measures (QM) for long stay (7), short stay (4) and staff retention

- Three tier system; higher tier equals better score on QMs

- More than half of Rockport facilities are at tiers two and three

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Nursing **Home** Care **in** Post **ACA** Era

SNFs instead of hospital
Increase capability to manage med/surg patients, Shorter LOS

Right Patient, Right Place
Direct patient to home care, assisted living, remote monitoring

Transfer from ED to SNF
Align incentives to avoid hospital care

ROCKPORT HEALTHCARE SERVICES

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What **questions** do **you** have **for** me?

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