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

THURSDAY, SEPTEMBER 8, 2016
8:00 A.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 11, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC)

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

A. Consider Recommendation of PAC Chair and Vice-Chair for FY 2016-2017

VI. CEO AND MANAGEMENT REPORTS

A. Chief Executive Officer (CEO) Update
B. Chief Financial Officer (CFO) Update
C. Chief Medical Officer (CMO) Update
D. Chief Operations Officer (COO) Update

VII. Information Items

A. Federal and State Budget Update
B. Whole Person Care Update
C. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

MINUTES

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

August 11, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 11, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Jena Jensen, PAC Chair, called the meeting to order at 8:06 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Alan Edwards, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Stephen N. Flood; Jena Jensen; Pamela Kahn, R.N.; George Orras, Ph.D.; FAAP; Pamela Pimentel, R.N.; Barry Ross, R.N., MPH, MBA
Members Absent:	Anjan Batra, M.D.; Teri Miranti; John Nishimoto, O.D.; Mary Pham, Pharm.D, CHC; Suzanne Richards, RN, MBA, FACHE; Jacob Sweidan, M.D.
Others Present:	Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Nancy Huang, Director, Finance; Arif Shaikh, Director, Government Affairs; Kelly Rex Kimmet, Director, Quality Analytics; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the June 9, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Pimentel seconded and carried, the Committee approved the minutes of the June 9, 2016 meeting. (Motion carried 10-0-0; Members Batra, Miranti, Nishimoto, Pham, Richards and Sweidan absent)***

PUBLIC COMMENTS
No requests for public comments were received.

On behalf of the PAC, Chair Jensen welcomed new PAC member Donald Bruhns as the Long Term Services and Support Representative. The PAC also presented recognition awards to Camille Fitzpatrick, Non-Physician Medical Practitioner Representative, and Cheryl Petterson, Long-Term Services and Support Representative in honor of their service on the PAC.

PAC Chair Jensen reordered the agenda to hear Agenda Items VII.B, Liberty Dental Presentation, VII.C, SCAN Foundation Cal MediConnect Satisfaction Survey Results presentation and VII.D, Illumination Foundation Presentation before continuing with the CEO and Management Reports.

PRESENTATIONS

Liberty Dental
Edward Bynam, Director of Special Projects, provided the PAC members with an overview of the current supplemental benefits provided to OneCare Connect members. Mr. Bynam noted that all Cal MediConnect providers in Liberty's network are also contracted with Denti-Cal to ensure seamless coordination of benefits.

The SCAN Foundation
Megan Juring, Program Officer, shared findings from Waves 1-3 of the Rapid Cycle Polling Project, a survey on California's Coordinated Care Initiative (CCI), which evaluated and tracked beneficiary transitions into Cal MediConnect (CMC) over time. Wave 3 included CMC enrollees and opt-outs in Orange and San Mateo Counties. Data for Wave 3 was collected between February and April 2016 and indicated that CMC enrollees had an 84% confidence in the Orange and San Mateo Plans. This was compared to the other counties who were surveyed in Waves 1 (76%) and 2 (73%). Waves 1 and 2 covered five counties - Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara Counties.

Illumination Foundation
Aiko Tan, Executive Director of Healthcare, and Paul Cho, Chief Financial Officer, presented on the safety net system for Orange County's chronically homeless population, and the Foundation's partnership with other health care organizations recuperative care program.

CEO AND MANAGEMENT REPORTS

Chief Financial Officer Update
Nancy Huang, Controller, presented CalOptima's Financial Summary for June 2016. Ms. Huang reviewed the financial highlights with the members noted that the total current assets were $1,768,751,279, total current liabilities were $1,608,744,299 and reserves as of June 20, 2016 were $476,135,365. Ms. Huang also reviewed the Health Network Enrollment Summary by Health Network and noted that total Medi-Cal enrollment was at 782,413 at the end of the fiscal year.

Chief Medical Officer Update
Dr. Richard Bock, Deputy Chief Medical Officer, provided a progress report on MedImpact, the new Pharmacy Benefits Manager (PBM).

He also discussed a supplemental survey that is being completed with help from the PAC CAHPS Ad Hoc Committee. Dr. Bock updated the PAC on how physicians are being educated about combating the current opioid epidemic. As part of the CMO report, Kelly Rex-Kimmet, Director, Quality Analytics, gave a HEDIS update on the Medi-Cal quality improvement performance measures and scores for both pediatric and adult care.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, notified the PAC that the Board of Directors approved the PAC's recommendation for a change to the Health Network Minimum Medi-Cal Enrollment Requirements, and authorized a change to CalOptima's Medi-Cal Policy EE.1106. Ms. Khamseh also noted that the Board approved a full 36 months for new Health Networks to reach and maintain a minimum 5,000 members. She noted that the Board expressed its appreciation to the PAC for its input and consideration.

Ms. Khamseh also updated the members on the ongoing Behavioral Health RFP process. Vendor interviews are currently in process. Member Ross inquired whether any of the comments from the joint MAC/PAC meeting on behavioral health in January 2016 were being taken into consideration when interviewing these vendors. Ms. Khamseh confirmed that they were.

INFORMATION ITEMS

Federal and State Budget Update
Arif Shaikh, Director, Government Affairs, provided a brief review of the State Budget Update and the Legislative Tracking Matrix that follows healthcare bills currently pending in the State Legislature.

PAC Member Comments
Member Caliendo thanked CalOptima for sponsoring the autism program that provides pediatric physicians with the tools and training necessary to make autism diagnoses. Dr. Caliendo noted that the program was well worth the time spent, and he would recommend it to his colleagues.

Chair Jensen reported that the addition of an advisory committee vice chair position was approved by the Board at its August meeting. She also noted that nominations for FY 2016-17 PAC Chair will be reopened as directed by the Board. Chair Jensen requested that any PAC member interested in the chair or vice chair position submit their name to the Staff to the PAC by August 19, 2016. The Nominations Ad Hoc Committee will be reconvened if necessary before the next PAC meeting to review, and recommend candidates for the chair and vice chair positions at the next PAC meeting.

ADJOURNMENT

There being no further business before the Committee, the PAC Chair adjourned the meeting at 10:05 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: September 8, 2016

MEMORANDUM

DATE:	September 1, 2016
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

Health Plan Associations and Advocates

CalOptima benefits from our active participation in leading health plan associations at the state and national level. Typically, the Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) prefer to work on large initiatives with associations instead of individual health plans. In addition, we maintain productive relationships with federal and state advocates who represent CalOptima in legislative and regulatory matters. Below are brief descriptions of our associations and advocates as well as short summaries of selected recent accomplishments.

STATE ASSOCIATIONS

California Association of Health Plans (CAHP): CAHP includes all 26 public and private health plans in California and has significant influence in Sacramento. Its mission is to create and sustain an environment that permits member plans to maintain or grow their organizations' ability to offer quality health care. In 2015, I was appointed to the CAHP Board of Directors, a position limited to only some CEOs of the member plans.

- Medi-Cal Rates: One of the major benefits of the association is to guide advocacy efforts with regard to Medi-Cal rates. Through its Rates Workgroup, CAHP works closely with DHCS to ensure that health plans receive adequate reimbursement rates to support access for members. While rates advocacy will continue to be a key issue for CalOptima, we are pleased with CAHP's efforts for FY 2016–17 to lessen Medi-Cal Expansion rate cuts and increase Medi-Cal Classic rates.
- Advocacy for Cal MediConnect: In his FY 2015–16 state budget proposal, Gov. Brown indicated that the Coordinated Care Initiative (CCI), which includes Cal MediConnect (OneCare Connect in Orange County), was not meeting financial benchmarks and could be eliminated by January 2017. CAHP took the lead in convening a CCI Workgroup of Cal MediConnect plans, associations and others to develop advocacy strategies and collect data. Reflecting the influence of the workgroup, the governor's FY 2016–17 budget proposal was more positive about the future of CCI, authorizing an extension through 2017. Under CAHP's leadership, the CCI Workgroup continues, and CalOptima actively participates by sharing data, attending meetings and providing information about OneCare Connect's success in Orange County.

Local Health Plans of California (LHPC): LHPC includes all 16 public, nonprofit plans that serve predominantly low-income individuals with Medi-Cal coverage. CEOs of all member plans are on the LHPC Board.

- CMS Medicaid Managed Care "Mega Reg": In April, CMS released a 1,425-page final rule that updates Medicaid managed care regulations. CMS' major goals in revising the regulations were to enhance beneficiary care and protections, strengthen payment provisions, promote quality of care, and support delivery system reform. LHPC plays a critical role for member organizations by providing analysis regarding the impact of the provisions. LHPC has convened meetings with DHCS to discuss implementation in California and set up a Mega Reg Workgroup, consisting of policy staff from plans.
- California Children's Services (CCS): In 2015, Sen. Ed Hernandez, with the support of the California Children's Hospital Association (CCHA), authored SB 586, a bill aimed at redesigning the CCS program. Funded by the state and administered by counties, CCS provides health care, case management and other services for children with episodic and chronic medical conditions, including cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer and traumatic injuries. LHPC continues to work closely with members of the Legislature, DHCS, CCHA and other entities to ensure that the bill language is in the best interest of the public plans and their members. LHPC has been involved in amendments to the bill and meetings with health plan CEOs and key influencers.

CalPACE: CalPACE is dedicated to the expansion of comprehensive health care for frail elderly and the promotion of PACE through education and advocacy. Members include 11 organizations that operate 30 PACE centers in California. CalOptima Director of Government Affairs Arif Shaikh is on the CalPACE Board of Directors.

- PACE Modernization Act: CalPACE was at the forefront of working with DHCS and the Legislature to draft the PACE Modernization Act, which is currently part of a state budget health trailer bill. The bill makes a variety of changes to improve the regulatory structure for PACE. Most notably, the bill would introduce a new process for calculating PACE reimbursement rates that is more likely to account for geographic rate disparity. First, reimbursement rates would be calculated taking into account actual cost data for each PACE center. Second, the rates would then be analyzed by a workgroup for actuarial soundness. Third, DHCS would be empowered to adjust the rates further to mitigate any remaining disparity. The act is especially important for CalOptima, since our Medi-Cal rates for PACE are among the lowest in the state.
- Enrollment Option in Cal MediConnect Materials: While Cal MediConnect and PACE are different programs, the target population they serve is the same — dual eligibles. When DHCS was developing an enrollment strategy for Cal MediConnect, CalPACE strongly advocated for inclusion of PACE as an option on the Cal MediConnect enrollment materials. During the OneCare Connect passive enrollment process, CalOptima was pleased that Orange County dual eligibles not only had an opportunity to enroll in that program but also in our PACE program. CalPACE's efforts in this initiative align with CalOptima's goal to ensure that members receive the right care for their needs.

NATIONAL ASSOCIATIONS

Association for Community Affiliated Plans (ACAP): Based in Washington, D.C., ACAP includes 61 community-based health plans in 24 states. ACAP has constructive and positive working relationships with federal legislators and regulators. ACAP conducts legislative advocacy with Congress on behalf of public plans in the Medicaid program and works well with CMS to support the efforts of plans operating Medicare programs. CalOptima is actively involved in ACAP programs, and I have been invited to speak at events on a regular basis.

- Medicare Rate Adjustment: ACAP was instrumental in CMS acknowledging that its risk-adjustment methodology under-predicts costs for dual eligibles in the various plans that provide Medicare benefits under managed care. CMS reviewed ACAP data (including some from CalOptima) that showed the payment methodology for dual eligibles resulted in payments that were too low given duals' medical conditions. Based on the new risk-adjustment methodology, CalOptima received a 7.4 percent Medicare base rate increase, retroactive to January 1, 2016, for OneCare Connect members. Beginning in 2017, the new risk-adjustment methodology will apply to both OneCare and OneCare Connect. In addition, ACAP is also asking CMS to reconsider its methodology for Star quality ratings in order to more fairly recognize the complexities of duals.
- Provider Directory Requirement: ACAP influenced a change related to a proposed CMS requirement regarding provider directories for Medicare plans. In light of findings that such directories were often inaccurate, CMS issued a letter stating that plans had to contact all providers monthly to verify the accuracy of information. CalOptima developed a presentation about the time and expense of that communication, which ACAP took to CMS. This resulted in CMS adjusting the frequency to quarterly — a major win in terms of eliminating a potentially burdensome requirement.

National PACE Association (NPA): Based in Alexandria, Va., NPA advances the efforts of PACE programs nationwide. Its membership includes 120 organizations in 31 states.

- Best Practices/Technical Assistance: On August 15, Peter Fitzgerald, NPA executive vice president of policy and strategy, toured CalOptima PACE and met with me, PACE Director Rena Smith and others. We had the opportunity to ask questions about operational best practices, and Mr. Fitzgerald made useful suggestions to boost efficiency and financial success. We also discussed our plan to use the Alternative Care Setting model to expand PACE, and he shared that a number of NPA members are pursuing this option because it has proven to be more flexible. Overall, we came away with renewed confidence that CalOptima PACE, at three years old, is performing consistent with national trends.
- CMS PACE Proposed Rule: CMS recently published a proposed rule to update PACE regulations. NPA is playing a critical role in helping organizations understand the regulation's impact and coordinating comments to CMS.

FEDERAL AND STATE ADVOCATES

James McConnell: Based in Washington, D.C., Mr. McConnell has represented CalOptima for a number of years, maintaining strong relationships with the Orange County delegation in the U.S. Senate and House of Representatives. He provides regular updates regarding health care topics at the federal level, including the Affordable Care Act and other key legislation.

- Protection of the County Organized Health System (COHS) Model: As one of only six COHS in the United States, CalOptima is a unique, mission-centered organization focused on providing access to quality, cost-effective care for members. Since the COHS model was established by federal statute, it is critical that members of Congress understand CalOptima and our community commitment. Mr. McConnell provides frequent updates to legislators to ensure they support CalOptima and the COHS model for Medi-Cal in Orange County.

Edelstein Gilbert Robson & Smith: Based in Sacramento, Trent Smith and Don Gilbert, partners at Edelstein, Gilbert Robson & Smith, serve as CalOptima's advocates at the state level. They provide representation on a wide variety of health care issues addressed by the legislators.

- Defeat of SB 260: Last year, Sen. Bill Monning, with the support of Western Center on Law & Poverty, authored a bill that would have required COHS plans to obtain a Knox-Keene license from the California Department of Managed Health Care. Knox-Keene licenses are for private health plans competing in a commercial marketplace. COHS plans are public entities and do not compete for Medi-Cal members. CalOptima and other COHS plans opposed SB 260, and Mr. Smith was extremely effective in lobbying against the bill. First, he set up multiple meetings between the COHS plans and Sen. Monning and his staff to ensure they understood the COHS model and clarify any misconceptions. However, once it was clear that Sen. Monning was moving forward with his bill, our advocates worked diligently to educate other legislators about the negative impacts of the bill, resulting in a defeat on the Assembly floor.
- Defeat of SB 1308: Introduced earlier this year, SB 1308 would have imposed financial restrictions on COHS plans, limiting spending on promotional giveaways, staff retreats, lobbying activities, certain media campaigns and other areas. COHS plans opposed SB 1308 because it undermined local control for the respective governing bodies of the health plans and oddly focused on spending when, in fact, COHS have among the lowest administrative costs of any Medi-Cal managed care model. Our advocates met with the bill's author, Sen. Ed Hernandez, chair of the Senate Health Committee, and other committee members to address concerns regarding the bill. As a result of this sustained lobbying effort, the author decided to drop the bill.

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

CalOptima PACE may soon be impacted by new legislation and regulation pending at the state and federal levels. A California budget health trailer bill contains the PACE Modernization Act. The act would make an adjustment to the PACE reimbursement process that is likely to significantly benefit our program by better accounting for geographic rate disparities. At the federal level, CMS published a proposed rule to update PACE regulations and build on the program's success. In releasing the rule, CMS stated that PACE programs have grown significantly in recent years yet the rules governing the programs have not changed in a decade. Therefore, CMS' proposal is designed to revise the requirements for PACE, aiming to provide organizations with more administrative and operational flexibility while strengthening protections and improving care for participants.

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Financial Summary

July 2016

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Chief Financial Officer

FY 2016-17: Consolidated Enrollment

- July 2016 MTD:
  - Overall enrollment was 799,083 member months
    - Actual higher than budget by 588 or 0.1%
      - Medi-Cal: favorable variance of 4,041 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 3,384 members
    - 1.0% decrease from prior month
      - OneCare Connect: decrease of 10,514 due to YTD true-up in June
      - Medi-Cal: increase of 2,120 from June 2016
    - 5.6% or 42,271 increase in enrollment from prior year

FY 2016-17: Consolidated Revenues

- July 2016 MTD:
  - ➢ Actual lower than budget by $1.5 million or 0.5%
    - Medi-Cal: favorable to budget by $7.7 million
      - Favorable price variance of $6.5 million due to higher enrollment and IHSS estimated revenue $4.1 million higher than budget
      - Favorable volume variance of $1.2 million
    - OneCare Connect: unfavorable variance of $9.7 million
      - Unfavorable price variance of $2.7 million due to cohort mix
      - Unfavorable volume variance of $7.0 million due to enrollment variance
    - OneCare: favorable to budget by $0.5 million

FY 2016-17: Consolidated Medical Expenses

- July 2016 MTD:
  - Actual lower than budget by $0.3 million or 0.1%
    - Medi-Cal: unfavorable variance of $9.8 million
      - Price variance of ($8.6) million due to IHSS estimated expenses $4.1 million higher than budget
      - Volume variance of ($1.2) million
    - OneCare Connect: favorable variance of $10.1 million
      - Price variance of $3.6 million mainly in Rx category
      - Volume variance of $6.6 million
- Medical Loss Ratio (MLR):
  - July 2016 MTD: Actual: 96.3% Budget: 95.9%

FY 2016-17: Consolidated Administrative Expenses

- July 2016 MTD:
  - Actual lower than budget by $3.4 million or 27.6%
    - Salaries and Benefits: favorable variance of $1.8 million driven by lower than budgeted FTE of 91
    - Other categories: favorable variance of $1.7 million

- Administrative Loss Ratio (ALR):
  - July 2016 MTD: Actual: 3.2% Budget: 4.5%

FY 2016-17: Change in Net Assets

- July 2016 MTD:
  - $1.7 million surplus
  - $2.6 million favorable to budget
    - Attributable to:
      - Lower administrative expenses of $3.4 million
      - Savings in medical expenses of $0.2 million
      - Higher investment income of $0.3 million
      - Offset by lower than budgeted revenue of $1.5 million

Enrollment Summary: July 2016

	Month-to-Date			
Enrollment (By Aid Category)	**Actual**	**Budget**	**Variance**	**%**
Aged	56,934	54,758	2,176	4.0%
BCCTP	635	675	(40)	(5.9%)
Disabled	48,453	47,539	914	1.9%
TANF Child	335,030	337,897	(2,867)	
MCE	230,537	221,527	9,010	4.1%
TANF Adult	104,008	109,730	(5,722)	(5.2%)
LTC	3,236	2,669	567	21.2%
Medi-Cal	**778,833**	**774,792**	**4,041**	**0.5%**
OneCare Connect	**18,902**	**22,286**	**(3,384)**	**(15.2%)**
PACE	**177**	**165**	**12**	**7.3%**
OneCare	**1,171**	**1,252**	**(81)**	**(6.5%)**
CalOptima Total	**799,083**	**798,495**	**588**	**0.1%**

Financial Highlights: July 2016

	Month-to-Date			
	Actual	Budget	$ Variance	% Variance
Member Months	799,083	798,495	588	0.1%
Revenues	279,561,710	281,047,454	(1,485,744)	(0.5%)
Medical Expenses	269,283,475	269,536,193	252,718	0.1%
Administrative Expenses	9,068,157	12,517,994	3,449,837	27.6%
Operating Margin	**1,210,078**	**(1,006,734)**	**2,216,812**	**(220.2%)**
Non Operating Income (Loss)	513,913	143,250	370,663	258.8%
Change in Net Assets	**1,723,991**	**(863,484)**	**2,587,475**	**(299.7%)**
Medical Loss Ratio	96.3%	95.9%	(0.4%)	
Administrative Loss Ratio	3.2%	4.5%	1.2%	
Operating Margin Ratio	0.4%	(0.4%)	0.8%	
Total Operating	100.0%	100.0%	0.0%	

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Consolidated Performance Actual vs. Budget: July 2016 (in millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	0.1	(0.7)	0.9
OneCare	0.2	0.0	0.2
OCC	1.0	0.0	1.0
PACE	(0.1)	(0.3)	0.2
Operating	**1.2**	**(1.0)**	**2.2**
Inv./Rental Inc, MCO tax	0.5	0.1	0.4
Non-Operating	**0.5**	**0.1**	**0.4**
TOTAL	**1.7**	**(0.9)**	**2.6**

Consolidated Revenue & Expense: July 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	548,296	230,537	$ 778,833	1,171	18,902	177	799,083
REVENUES							
Capitation Revenue	135,855,683	104,512,152	$ 240,367,835	$ 1,909,332	$ 36,216,029	$ 1,068,515	$ 279,561,710
Other Income	-		-	-	-	-	-
Total Operating Revenues	135,855,683	104,512,152	240,367,835	1,909,332	36,216,029	1,068,515	279,561,710
MEDICAL EXPENSES							
Provider Capitation	32,531,374	42,062,700	74,594,073	372,155	8,173,122	113	83,139,464
Facilitities	26,736,302	34,828,873	61,565,175	605,024	9,385,123	325,487	71,880,809
Ancillary				36,727	524,096	-	560,824
Skilled Nursing				42,814	5,054,277	-	5,097,091
Professional Claims	12,706,695	4,304,271	17,010,966	-	-	214,223	17,225,188
Prescription Drugs	16,769,736	15,993,602	32,763,338	487,704	8,401,395	96,410	41,748,847
Quality Incentives					378,780		378,780
Long-term Care Facility Payments	38,010,650	6,032,845	44,043,496	-	-	5,601	44,049,097
Contingencies	-	-	-	-	-	-	-
Medical Management	3,061,704	-	3,061,704	28,089	972,124	353,698	4,415,616
Reinsurance & Other	(378,657)	972,456	593,799	5,209	107,004	81,748	787,759
Total Medical Expenses	129,437,804	104,194,747	233,632,551	1,577,722	32,995,922	1,077,280	269,283,475
Medical Loss Ratio	**95.3%**	**99.7%**	**97.2%**	**82.6%**	**91.1%**	**100.8%**	**96.3%**
GROSS MARGIN	6,417,879	317,404	**6,735,283**	**331,610**	**3,220,107**	**(8,766)**	**10,278,235**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,307,828	17,843	1,093,502	89,921	6,509,095
Professional Fees			185,211	22,000	103,950	4,938	316,099
Purchased Services			591,820	20,280	116,934	0	729,034
Printing and Postage			122,064	2,385	14,418	222	139,089
Depreciation and Amortization			264,591			2,014	266,605
Other Expenses			726,221	714	1,492	9,037	737,463
Indirect Cost Allocation, Occupancy Expense			(598,659)	29,494	937,491	2,446	370,771
Total Administrative Expenses			6,599,076	92,716	2,267,787	108,578	9,068,157
Admin Loss Ratio			**2.7%**	**4.9%**	**6.3%**	**10.2%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			136,207	238,894	952,320	(117,344)	1,210,078
INVESTMENT INCOME			-	-	-	-	510,861
NET RENTAL INCOME			-	-	-	-	2,800
OTHER INCOME			252	-	-	-	252
CHANGE IN NET ASSETS			**$ 136,459**	**$ 238,894**	**$ 952,320**	**$ (117,344)**	**$ 1,723,991**
BUDGETED CHANGE IN ASSETS			(713,688)	29,395	(29,527)	(292,914)	(863,484)
VARIANCE TO BUDGET - FAV (UNFAV)			850,147	209,499	981,847	175,570	2,587,475

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Balance Sheet: As of July 2016

ASSETS		
Current Assets		
	Operating Cash	$475,725,744
	Catastrophic Reserves	11,633,210
	Investments	1,134,227,219
	Capitation receivable	234,516,162
	Receivables - Other	20,291,900
	Prepaid Expenses	11,935,241
	Total Current Assets	**1,888,329,476**
Capital Assets	Furniture and equipment	28,851,790
	Leasehold improvements	11,762,557
	505 City Parkway West	46,707,144
		87,321,491
	Less: accumulated depreciation	(32,262,681)
	Capital assets, net	**55,058,810**
Other Assets	Restricted deposit & Other	279,518
	Board-designated assets	
	Cash and cash equivalents	3,104,519
	Long term investments	472,836,571
	Total Board-designated Assets	475,941,090
	Total Other Assets	**476,220,608**
	Deferred outflows of Resources - Pension contributions	**3,787,544**
	Deferred outflows of Resources - Difference in Experience	**1,215,473**
TOTAL ASSETS & OUTFLOWS		**2,424,611,911**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$14,887,899
	Medical claims liability	613,681,231
	Accrued payroll liabilities	8,867,872
	Deferred revenue	673,243,791
	Deferred revenue - CMS	0
	Deferred lease obligations	267,070
	Capitation and withholds	414,314,900
	Total Current Liabilities	**1,725,262,764**
	Other (than pensions) post employment benefits liability	27,594,452
	Net Pension Liabilities	8,158,985
	Long Term Liabilities	150,000
	TOTAL LIABILITIES	**1,761,166,201**
	Deferred inflows of Resources - Excess Earnings	**502,900**
	Deferred inflows of Resources - changes in Assumptions	**1,651,640**
	Tangible net equity (TNE)	89,012,314
	Funds in excess of TNE	572,278,856
Net Assets		**661,291,170**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,424,611,911**

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Board Designated Reserve and TNE Analysis As of July 2016

CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,383,499				
	Tier 1 - Logan Circle	125,385,604				
	Tier 1 - Wells Capital	125,378,616				
Board-designated Reserve						
		386,147,719	286,467,328	447,387,174	99,680,391	(61,239,455)
TNE Requirement	Tier 2 - Logan Circle	89,793,371	89,012,314	89,012,314	781,057	781,057
	Consolidated:	**475,941,090**	**375,479,642**	**536,399,488**	**100,461,449**	**(60,458,398)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

HN Enrollment Summary - Medi-Cal

Health Network Name	August 2016	Percentage
CHOC Health Alliance (PHC20)	155,253	19.9%
Monarch Family HealthCare (SRG68)	90,406	11.6%
Arta Western Health Network (SRG66)	79,682	10.2%
CalOptima Community Network (CN)	64,401	8.3%
Family Choice Health Network (PHC21)	49,657	6.4%
Kaiser Permanente (HMO04)	45,045	5.8%
Alta Med Health Services (SRG69)	38,984	5.0%
Prospect Medical Group (SRG63)	37,301	4.8%
United Care Medical Network (SRG67)	36,090	4.6%
Noble Mid-Orange County (SRG64)	34,990	4.5%
Talbert Medical Group (SRG65)	26,258	3.4%
AMVI Care Health Network (PHC58)	25,341	3.2%
Heritage - Regal Medical Group (HMO15)	2,661	0.3%
OC Advantage (PHC35)	758	0.1%
Total Health Network Capitated Enrollment	**686,824**	**88.0%**
CalOptima Direct (all others)	93,576	12.0%
Total Medi-Cal Enrollment	**780,400**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	August 2016	Percentage
Monarch HealthCare (PMG53DE)	659	55.3%
AMVI/Prospect Medical Group (PMG27DE)	297	24.9%
Talbert Medical Group (PMG52DE)	100	8.4%
Family Choice Medical Group (PMG21DE)	57	4.8%
Arta Western Health Network (PMG66DE)	34	2.9%
Alta-Med (PMG69DE)	21	1.8%
United Care Medical Group (PMG67DE)	20	1.7%
Noble Mid Orange County (PMG64DE)	4	0.3%
Total OneCare Enrollment	**1,192**	**100.0%**

HN Enrollment Summary – OneCare Connect

Health Network Name	August 2016	Percentage
Monarch HealthCare (SRG53DE)	5,693	30.9%
Propect Medical Group (SRG63DB)	3,530	19.2%
CalOptima Community Network (CN)	2,093	11.4%
Family Choice Medical Group (SRG81DB)	2,029	11.0%
Talbert Medical Group (SRG52DB)	1,309	7.1%
AMVI Care Health Network (PHC58DB)	752	4.1%
Arta Western Health Network(SRG66DB)	734	4.0%
United Care Medical Group (SRG67DB)	734	4.0%
Alta-Med (SRG69DB)	595	3.2%
Noble Mid Orange County (SRG64DB)	552	3.0%
Heritage - Regal Medical Group (HMO15)	268	1.5%
OC Advantage (PHC35DB)	138	0.7%
Total OneCare Connect Enrollment	**18,427**	**100.0%**


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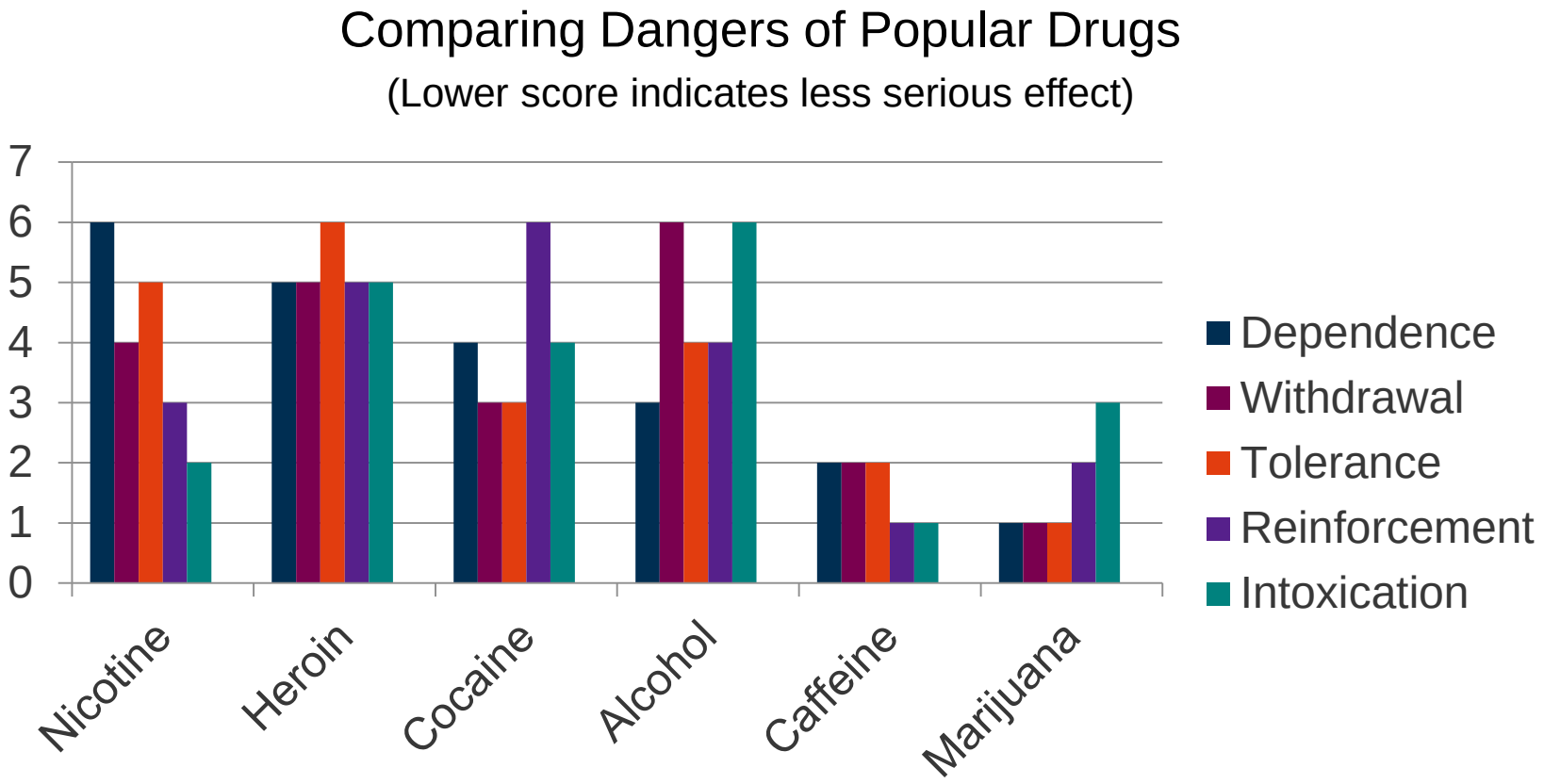
More Dangerous than Opioids?

Provider Advisory Committee
September 8, 2016

Richard Bock, MD
Deputy Chief Medical Officer

More Dangerous Than Opioids?



Dependence: How difficult it is for the user to quit, the relapse rate, the percentage of people who eventually become dependent, the rating users give their own need for the substance and the degree to which the substance will be used in the face of evidence that it causes harm.

Cost of Smoking

- Tobacco use is the single most preventable cause of death and disease in California, claiming the lives of more than 40,000 people every year
- Tobacco use costs Californians more than $13.29 billion in healthcare expenses every year, of which $3.5 billion is paid for by taxpayers through Medi-Cal
- $3.5 billion public health cost/817 million packs sold in CA = $4.28 per pack
- In New York State, lower income smokers spent 23.6% of their income on cigarettes, compared to 2% higher income residents and an average of 14% among lower-income smokers nationally

E-Cigs Threaten Our Children

- The fastest growing age range for electronic cigarettes is middle school and high school students. Use among this group tripled from 2013 to 2014.
- There are more than 470 electronic cigarette brands for sale today offered in over 7,700 flavors including candy flavors that appeal to youth, such as Captain Crunch, gummy bear, cotton candy, atomic fireball, and fruit loops.
- The 2012 Surgeon General's Report found that about 90 percent of all smokers first tried cigarettes as teens; and that about three of every four teen smokers continue into adulthood.

E-Cigs Threaten Our Children (cont.)

- E-cigarettes are not substituting for cigarettes. Instead, adolescents who would have not otherwise used tobacco products are picking up the nicotine habit.
- *"Adolescence is a critical time for brain development. Nicotine exposure at a young age may cause lasting harm to brain development, promote addiction, and lead to sustained tobacco use."* from CDC Director Tom Frieden, MD, MPH - August 2016 Pediatrics.

Safer for Whom?

- There are no requirements that manufacturers test their e-liquids, nor are there any standards to meet
- Electronic cigarettes are currently not subject to any tobacco taxation, making them cheaper and potentially more attractive, especially to young people
- The number of young people using e-cigarettes tripled last year, according to data the CDC published in April. Roughly 2 million high schoolers — about 13% reported they had used an e-cigarette in the last 30 days, findings from the 2014 National Youth Tobacco Survey show
- Most electronic cigarettes contain nicotine, which is derived from tobacco and is a highly addictive drug.

Safer for Whom? (cont.)

- Harvard University scientists are calling for “urgent action” after their federally funded study confirmed dangerous, lung-destroying chemicals are commonly found in liquids used in electronic cigarettes and other vaping devices.

Toxic Vaping

The solvents found in most e-cigarette “e-liquids” emit toxic chemicals such as acrolein and formaldehyde when heated, according to a new Berkeley Lab Study.

31=number of toxic chemicals Berkeley Lab researchers found at significant levels in e-cigarette vapor.

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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Pay-for-Value
Provider Advisory Committee

Richard Bock, MD Deputy CMO
Medical Affairs

What's new…..

- Achieved NCQA Accreditation – Commendable Status!
  - Showed improvement in Member Experience/Satisfaction
  - Showed declining scores in Clinical Quality
- Finalizing 2015 Scoring and Payment P4P
- Completing the Scoring Methodology for the 2016 P4V Program
- Recognizing our obligations
  - Accreditation Measures (30 HEDIS; 7 CAHPS)
  - Quality Withhold Measures (6 Measures)
  - DHCS Minimum Performance Level Measures (19 measures)
  - Stars Measures (27 Measures)

So, How Did We Do On Accreditation?

	2015	2016
HEDIS (out of 37 points)	25.3943	22.9530
CAHPS (out of 13 points)	4.3550	7.4100
Total HEDIS Score (HEDIS and CAHPS out of 50 points)	29.7493	30.3630
Standards Score (out of 50 points)	50.0000	50.0000
Total Score	**79.74930**	**80.3630**
Accreditation Rating	**Accredited**	**Commendable**

Pay for *Value* - 2016

- Goals of the current program & methodology
  - Adult & Child measures are included for every Health Network
  - Populations are weighted based on the acuity of the membership
  - Payment considers the resources required for the membership
  - Payment methodology scores for performance and improvement
  - Adult & Child CAHPS scores are used in the methodology
  - Payment is not earned for poor performance
  - Design incentive payments to optimize quality improvement

Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures	
Adult Measures	Child Measures
Adult Access to Preventive Care Services	Children's Access to Primary Care Physicians
Breast Cancer Screening	Well Child Visits 3-6 Years
Cervical Cancer Screening	Adolescent Well Care Visits
Diabetes Care: A1C Testing	Childhood Immunizations (Combo 10)
Diabetes Care: Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis
Medication Management for People with Asthma	Appropriate Treatment for Children with URI
	Medication Management for People with Asthma

MediCal P4V CAHPS Measures

2016 Measurement Year Measures
Child & Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of PCP
Rating of all HealthCare

Introduced Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- CalOptima has included these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Display Measures:
  - Ambulatory Care (Outpatient and ER visits)
  - Readmissions
  - IHA completion rates

Payment Methodology

Population Included:	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Payment	
50% based on Performance score and 50% based on Improvement score Improvement score will be weighted by CalOptima's overall improvement	
Clinical Measures = 60% of the Total	CAHPS Measures = 40% of the Total
Proposed Scoring for Measure Performance:	
• A relative point system by measure, based on: • NCQA National HEDIS Percentiles (clinical measures) • NCQA National CAHPS Percentiles (satisfaction measures) • Final score is the sum of points for each measure • Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing)	

OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect
1. Plan All Cause Readmissions
2. Behavioral Health: • Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

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LEGISLATIVE TRACKING MATRIX

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 586 Hernandez	Authorizes the Department of Health Care Services (DHCS) to establish a Whole Child Model program that would transition the California Children's Services (CCS) program from the fee-for-service (FFS) delivery model to Medi-Cal managed care in specified health plans, including CalOptima. Requires CalOptima to provide CCS benefits for 11,810 CCS-enrolled children in Orange County.	**08/29/2016** – Passed Senate, ordered to enrolling to be sent to Governor	Watch
SB 833 Committee on Budget and Fiscal Review	Omnibus health trailer bill, which contains various fiscal changes to state-funded health programs. Most importantly for CalOptima, the bill would make changes to PACE programs by reforming the DHCS rate-setting methodology to address the unique features of PACE programs, such as drug costs, treatments, and day care activities. DHCS would be required to calculate a new upper payment limit for PACE, which will be 1) Based on utilization data, 2) Actuarially certified, and 3) Adjusted for geographic rate disparities, when appropriate. It is expected the new rate methodology will take effect by late 2017 or early 2018, subject to the current work of the actuarial workgroup, and, final approval from CMS.	**06/27/2016 –** Approved by Governor	Watch
SB 1010 Hernandez	Requires health plans or insurers, including CalOptima, to submit prescription drug rate information to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). Requires drug manufacturers to justify their drug prices in these situations.	**08/11/2016** – Removed from Assembly at the request of the author	Watch
SB 1034 Mitchell	Prohibits health plans from denying medically necessary Behavioral Health Treatment (BHT) services for members with Autism Spectrum Disorder (ASD) based on setting, location, time of treatment, or lack of parent/caregiver participation. CalOptima already complies with the current provisions of this bill. Eliminates the sunset date on the health insurance mandate for plans to cover BHT services.	**08/11/2016 –** Held under submission	Watch
SB 1135 Monning	Requires health plans, including Medi-Cal managed care plans, to provide information to both enrollees and providers regarding standards for timely access to care; specifically, wait times for specialty and primary care services, telephone screenings, and available interpreter services. CalOptima would be required by state law to provide the aforementioned information to contracted providers no less than annually, inform enrollees upon enrollment and no less than annually, and publish	**08/24/2016 –** Passed Senate, ordered to enrolling to be sent to Governor	Watch

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	the information on our website.		
SB 1273 Moorlach	Clarifies that Mental Health Services Act (MHSA) funds may be used by county mental health programs to provide outpatient crisis stabilization services (CSS) for eligible individuals. This bill does not directly impact CalOptima, but clarifies that individuals (including CalOptima members) in need of CSS can receive outpatient care funded by MHSA.	**08/19/2016** – Removed at the request of the author	Support
SB 1308 Nguyen	Prohibits County Organized Health Systems (COHS), including CalOptima, from utilizing funds for staff retreats, promotional giveaways, or excessive executive compensation. Prohibits COHS from purchasing media campaigns that feature elected public officials.	**04/06/2016** –Removed from Senate Committee on Health hearing agenda at the request of the author	Oppose
SB 1361 Nielsen	Restores Medi-Cal coverage to provide one pair of eyeglasses every two years to a beneficiary over 21 years old whose vision is equal to or poorer than 20/40. Makes changes to vision benefits for CalOptima members.	**05/27/2016** – Held under submission	Watch
SB 1377 Nguyen	Appropriates $3.3 million from the General Fund to DHCS for allocation to contract with 11 non-profit Caregiver Resource Centers statewide, including one in Orange County. May potentially benefit caregivers that support cognitively impaired CalOptima members.	**05/27/2016** – Held under submission	Watch
SB 1436 Bates	Requires that final action on a local public agency's executive salary, salary schedule, or compensation paid in the form of fringe benefits be made a separate discussion item and not placed on the agency's consent calendar. Makes a procedural change to require an oral summary report of the merit increases for the specified executives before final action is taken.	**08/22/2016** – Approved by Governor	Watch
AB 1051 Maienschein	Appropriates $200 million from the General Fund to the DHCS for the Denti-Cal program, and requires DHCS to allocate these funds to increase funding for preventative care and case management services. Members who receive Denti-Cal benefits outside of CalOptima may be affected by the potential funding increase for the Denti-Cal program.	**08/11/2016 –** Held under submission	Watch

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
AB 1605 Committee on Budget	Omnibus health trailer bill, which contains various fiscal changes to state-funded health programs. Most importantly for CalOptima, the bill would make changes to PACE programs by reforming the DHCS rate-setting methodology to address the unique features of PACE programs, such as drug costs, treatments, and day care activities. DHCS would be required to calculate a new upper payment limit for PACE, which will be 1) Based on utilization data, 2) Actuarially certified, and 3) Adjusted for geographic rate disparities, when appropriate. It is expected the new rate methodology will take effect by late 2017 or early 2018, subject to the current work of the actuarial workgroup, and, final approval from CMS.	**08/23/2016 –** Ordered to Senate inactive file	Watch
AB 1696 Holden	Expands tobacco cessation benefits for Medi-Cal managed care plans, including increasing the number of quit attempts, expanding the list of approved medication types, and eliminating the care authorization requirement.	**08/23/2016** – Passed Assembly, ordered to enrolling to be sent to Governor	Watch
AB 1795 Atkins	Increases funding and expands benefits of the Breast and Cervical Cancer Treatment Program (BCCTP) by extending treatment services from 18 to 24 months to the total duration of service needed for the individual, so long as the individual continues to meet eligibility requirements. May affect up to approximately 650 CalOptima members who currently receive BCCTP benefits.	**08/30/2016** – Passed Assembly, ordered to enrolling to be sent to Governor	Watch
AB 2077 Burke Bonilla	Establishes procedures to ensure that beneficiaries who move between Medi-Cal and Covered California do not experience any breaks in coverage, and prohibits Medi-Cal benefits from being terminated until at least 20 days after a Notice of Action (NOA) is sent to the beneficiary from the county social services department. Under current law, NOAs are sent to Medi-Cal beneficiaries to notify them of any changes to their eligibility 10 days prior to the termination of Medi-Cal benefits.	**08/31/2016** – Passed Assembly, ordered to enrolling to be sent to Governor	Watch
AB 2084 Wood	Requires comprehensive medication management (CMM) services to be a covered benefit under Medi-Cal, and requires plans that administer CMM services include the development and implementation of a written medication treatment plan.	**05/27/2016** – Held under submission	Watch
AB 2207 Wood	Adds performance measures for the Denti-Cal FFS program and seeks to improve access to care for Denti-Cal beneficiaries by increasing the number of providers. May affect CalOptima members receiving Denti-Cal services.	**08/24/2016** – Passed Senate, ordered to enrolling to be sent to Governor	Watch

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
AB 2394 Garcia	Requires Medi-Cal health plans to provide non medical transportation (NMT) services for Medi-Cal beneficiaries. Expands NMT benefits for any form of public or private transportation, as well as mileage reimbursement. Makes changes to transportation benefits for CalOptima members.	**08/24/2016** — Passed Assembly, ordered to enrolling to be sent to Governor	Watch
AB 2507 Gordon	Adds video and telephone communications to the definition of telehealth. Provides that the required consent from beneficiaries for telehealth services may be digital, oral, or written. As currently drafted, this bill will not change CalOptima's services or policies, as these benefits are already provided. However, it may relax restrictions for beneficiaries to approve the use of telemedicine.	**05/27/2016** – Held under submission	Watch
AB 2670 Hernández	Requires DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan survey, which is developed for all Medi-Cal managed care plans. Increases the frequency of the survey, and requires it to be administered in all threshold languages. Requires the survey to show detailed information on how factors such as location, ethnicity, and gender play into quality of health care.	**05/27/2016** – Held under submission	Watch
AB 2752 Nazarian	Requires health plans to notify members if a prescription drug is no longer covered by the plan, or if the plan changes its policy to no longer offer a specific drug. Requires plans to annually update their provider directory with prescription drug information and to inform members through annual renewal materials if a prescription drug is no longer covered by their provider.	**05/27/2016** – Held under submission	Watch
AB 2821 Chiu	Requires the Department of Housing and Community Development (HCD) to coordinate with DHCS to establish a housing program for Medi-Cal beneficiaries and award grants to government agencies participating in a Whole Person Care (WPC) pilot program. Allows HCA to be eligible to receive these grant funds which may affect up to approximately 7,300 homeless CalOptima members.	**08/29/2016** – Passed Assembly, ordered to enrolling to be sent to Governor	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely followed and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

UPCOMING LEGISLATIVE DEADLINES

Final Recess Deadlines

Sept. 30: Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1

Oct. 2: Bills enacted on or before this date take effect Jan. 1, 2017

Nov. 8: General Election

Nov. 30 Legislature officially adjourns at midnight

Dec. 5: 2017-18 Regular Session convenes for Organizational Session at 12:00 p.m.

2017

Jan. 1: Statutes take effect

* Holiday schedule subject to final approval by Rules Committee

About CalOptima

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

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

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Sources: Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Whole Person Care Pilot

CalOptima Provider Advisory Committee Meeting

September 8, 2016

Cheryl Meronk, Director, Strategic Development

Introduction

- The Whole Person Care (WPC) pilot program is part of Medi-Cal 2020, California's latest 1115 waiver

- Four new initiatives:
  - **Whole Person Care (WPC)**
  - Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
  - Global Payment Program (GPP)
  - Dental Transformation Initiative (DTI)

WPC Overview

- County-based pilots
  - Improve health and well-being of individuals that frequently use multiple systems of care/support
  - Increase coordination between behavioral health and social services
- Provides funding for care coordination and infrastructure development (e.g. IT systems to facilitate data sharing)
- Available funding:
  - $300 million per year for five years
  - Requires local government funding match

WPC in Orange County

- Lead entity: County of Orange, Health Care Agency
  - Has submitted Orange County WPC pilot application to DHCS
  - Will act as point of contact with the state
  - Will furnish required local matching funds and receive WPC payments
- CalOptima's role: Required WPC participant as the county's Medi-Cal managed care plan
- Focus of Orange County WPC pilot:
  - Homeless population and Seriously Mentally Ill population
    - Reduce inappropriate emergency and inpatient utilization
    - Increase coordination and appropriate access to care
    - Improve Health Outcomes for the WPC Pilot population

WPC in Orange County (Cont.)

- Participating agencies:
  - 2-1-1 Orange County
  - Buena Park Community Clinic
  - CalOptima
  - County of Orange, Community Resources, Homeless Prevention
  - County of Orange, Health Care Agency (Lead Entity)
  - County of Orange, Health Care Agency, Behavioral Health Services (BHS)
  - Hoag Hospital
  - Hurtt Family Health Clinic
  - Illumination Foundation
  - Korean Community Services
  - Lestonnac Free Clinic
  - Orange County Community Resources
  - Saddleback Memorial Hospital and Orange Coast Memorial Hospital
  - Safety Net Connect
  - Serve The People
  - Share Our Selves
  - St. Joseph Hospital
  - St. Jude Medical Center
  - UCI Medical Center

Timeline

July 1, 2016: Application due to DHCS

September 2016: DHCS completes review of applications and clarifies open questions with applicants

October 24, 2016: DHCS makes final decisions, notifies applicants and CMS

November 3, 2016: WPC lead entities provide formal acceptance to DHCS

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Medi-Cal

OneCare (HMO SNP)

OneCare Connect

PACE