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

THURSDAY, OCTOBER 12, 2017
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 10, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee
B. Approve Minutes of the September 14, 2017 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) Meeting

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 Operating Officer (COO) Update
C. Chief Medical Officer (CMO) Update
D. Chief Financial Officer (CFO) Update
E. Network Operations Update
F. Federal and State Legislative Update

VII. INFORMATION ITEMS

A. Update on Behavioral Health Transition
B. Whole Child Care Model
C. Palliative Care Update
D. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

Back to Agenda

MINUTES

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

August 10, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 10, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:04 a.m., and Member Flood led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Alan Edwards, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; John Nishimoto, O.D.; George Orras, Ph.D., FAAP; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: Theodore Caliendo, M.D.; Mary Pham, Pharm.D, CHC

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Helmer, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Arif Shaikh, Director, Government Affairs; Cheryl Meronk, Director, Strategic Development; Kelly Rex-Kimmet, Director, Quality Analytics; Cheryl Simmons, Staff to the Provider Advisory Committee

MINUTES

Approve the Minutes of the June 8, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the June 8, 2017 meeting. (Motion carried 13-0-0; Members Caliendo and Pham absent)***

PUBLIC COMMENTS

No requests for public comment were received.

Back to Agenda

Chair Miranti welcomed Craig G. Myers to the PAC as the new Community Health Centers Representative. Mr. Myers formerly held the Hospital seat from 2011-2013. The PAC also recognized Member Barry Ross for his six years of service as the Community Health Centers Representative. Mr. Ross thanked the PAC members, CalOptima leadership and staff for their support during the last six years.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, updated the PAC on healthcare reform as well as the Magellan contract for behavioral health services for Medi-Cal members. At the August 3, 2017 meeting, the CalOptima Board of Directors authorized extending the current contract with Magellan through December 31, 2017, and Board Chair Paul Yost formed an ad hoc to evaluate options for Board consideration, including a possible extension of the current contract with Magellan beyond December 31, 2017. Several PAC members indicated their support should CalOptima consider administering the Medi-Cal behavioral health benefit in-house, if necessary, on January 1, 2018.

Mr. Schrader also discussed the three-way non-binding Master Services Agreement that was approved by the Board at their August 3, 2017 meeting. The non-binding agreement between LA Care, Inland Empire Health Plan and CalOptima allows for partnership and engagement with the University of California (UC) Health System. The purpose of the agreement is to work with the UC system to contract with several of the UC HealthCare system hospitals such as UC Davis, UC Irvine and UCLA, including for services not available in Orange County. Currently CalOptima works with out of county providers including the University of Southern California (USC) Keck School of Medicine, City of Hope and Cedars Sinai to access such services as necessary.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, discussed the current OneCare Connect (OCC) 30-day deeming period, and noted that DHCS is now requiring health plans to extend the deeming period to two months. Ms. Khamseh also updated the PAC on the non-medical transportation benefit that became effective July 1, 2017 for CalOptima Medi-Cal members. Ms. Khamseh noted that a Request for Proposal (RFP) process will be conducted in the near future for non-medical transportation services. Ms. Khamseh also discussed Medi-Cal Client Index Numbers (CIN) for newborns. She noted that the State considers the mother's Medi-Cal eligibility to cover the newborn for the month of birth and the month afterward, unless the newborn is assigned its own CIN number.

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, discussed Senate Bill 1004 on Palliative Care that would mandate that palliative care be implemented in Medi-Cal plans. He also noted that there would be no additional payment received from the State. CalOptima is currently working to insure that we meet regulatory requirements and will continue to work with the networks and hospitals before the January 1, 2018 implementation date.

Back to Agenda

Dr. Helmer updated the members on the process to allow for the credentialing of optometrists who are not contracted with VSP. Dr. Helmer noted that an internal ad hoc to review payment methodology to insure CalOptima is paying Optometrists properly. Member Nishimoto, a practicing optometrist volunteered to serve on the ad hoc based on his role as a Non-Medical Practitioner.

Dr. Helmer also discussed the Request for Information (RFI) that was recently released for PACE Alternative Care Settings to evaluate expanding PACE countywide, and responses are being clarified. In addition, an RFI for perinatal support services is being finalized for release to identify capabilities in the county. Dr. Helmer also noted that a Pay For Value (P4V) program is being developed for the CalOptima Community Network (CCN).

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's Financial Summary as of June 2017, including a report of the Health Network Enrollment for the month of June 2017. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Federal and State Budget Update

Arif Shaikh, Director, Government Affairs, provided updates on Congressional activities around the reauthorization of funding for the Children's Health Insurance Program (CHIP), as well as the reauthorization of Dual Eligible Special Needs Plans (D-SNPs). Mr. Shaikh noted that approximately 110,000 CalOptima members are impacted by CHIP funding, and the reauthorization of the program is critical to ensure financial sustainability for the state. CHIP funding is authorized through September 2017; D-SNPs are authorized by Congress through the end of 2018. CalOptima currently has approximately 1,200 dual-eligible seniors enrolled in its D-SNP, OneCare.

Cheryl Meronk, Director, Strategic Planning, presented an overview of the approved Intergovernmental Transfer (IGT) Funds, and the most recent Board approved funding categories for IGT 6 and 7. IGT 6 and 7 funds will be used to deliver enhanced services for the Medi-Cal population, in the primary categories of opioid and other substance overuse, children's mental health, homeless health, and community grants to support program areas beyond those funded by IGT 5. Proposed expenditure plans will be presented to the Board after receiving input from the PAC and other stakeholder groups.

INFORMATION ITEMS

Program Implementation Updates

Candice Gomez, Executive Director, Program Implementation, presented an update the status of various programs that were recently implemented or are in the process of being implemented. Ms. Gomez noted that the County-led Whole Person Care started on July 1, 2017. This program increases the coordination of physical, behavioral health and social services for CalOptima members who are homeless or have a behavioral health condition and are at risk of being homeless. Services include recuperative care, housing support services and mental health

services. Ms. Gomez also noted that Palliative Care is slated to take effect on January 1, 2018. The Health Homes Program and the Whole Child Model are anticipated to begin on January 1, 2019.

HEDIS 2017 Results

Kelly Rex-Kimmet, Director, Quality Analytics, presented the annual HEDIS results for 2017 and noted that CalOptima met all Department of Health Care Services (DHCS) minimum performance levels.

PAC Member Information

Chair Miranti reminded the PAC members that the September 14, 2017 meeting would be a joint meeting with the Member Advisory Committee (MAC). She asked the members to review the draft agenda in their folders and provide any additional topic recommendations.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:03 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: October 12, 2017

Back to Agenda

Financial Summary

August 2017

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2017-18: Consolidated Enrollment

- August 2017 MTD:
  - Overall enrollment was 797,991 member months
    - Actual lower than budget by 4,055 or 0.5%
      - Medi-Cal: unfavorable variance of 3,842 members
        - TANF unfavorable variance of 7,263 members
        - SPD unfavorable variance of 2,093 members
        - Medi-Cal Expansion (MCE) favorable variance of 5,289 members
        - LTC favorable variance of 225 members
      - OneCare Connect: unfavorable variance of 274 members
    - 10,305 or 1.3% increase from prior month
      - Medi-Cal: increase of 10,416 from July
      - OneCare Connect: decrease of 136 from July
      - OneCare: increase of 19 from July
      - PACE: increase of 6 from July

FY 2017-18: Consolidated Enrollment

- August 2017 YTD:
  - Overall enrollment was 1,585,677 member months
    - Actual lower than budget by 18,085 or 1.1%
      - Medi-Cal: unfavorable variance of 17,800 members
        - TANF unfavorable variance of 21,146 members
        - SPD unfavorable variance of 4,734 members
        - MCE favorable variance of 7,747 members
        - LTC favorable variance of 334 members
      - OneCare Connect: unfavorable variance of 397 members or 1.3%
      - OneCare: favorable variance of 113 members or 4.3%
      - PACE: unfavorable variance of 1 member or 0.2%

FY 2017-18: Consolidated Revenues

- August 2017 MTD:
  - ➢ Actual higher than budget by $8.7 million or 3.1%
    - Medi-Cal: favorable to budget by $8.7 million or 3.6%
      - Unfavorable volume variance of $1.2 million
      - Favorable price variance of $9.9 million due to:
        - ➢ $5.8 million of Fiscal Year (FY) 2018 revenue for In-Home Supportive Services (IHSS) and Behavioral Health Treatment (BHT)
        - ➢ $1.9 million of FY 2016 and 2017 LTC related revenue recognized for members with Non-LTC aid codes
        - ➢ $1.1 million FY 2017 revenue for Coordinated Care Initiative (CCI)
    - OneCare Connect: unfavorable to budget by $0.5 million or 1.7%
      - Unfavorable volume variance of $0.5 million due to lower enrollment

FY 2017-18: Consolidated Revenues (con't.)

- August 2017 YTD:
  - Actual higher than budget by $11.7 million or 2.1%
    - Medi-Cal: favorable to budget by $12.4 million or 2.5%
      - Unfavorable volume variance of $5.6 million
      - Favorable price variance of $18.0 million due to:
        - $11.7 million from prior year revenue
        - $2.4 million from FY 2018 revenue for BHT
    - OneCare Connect: unfavorable to budget by $1.3 million or 2.3%
      - Unfavorable volume variance of $0.7 million
      - Unfavorable price variance of $0.6 million
    - OneCare: favorable to budget by $0.2 million or 8.3%
    - PACE: favorable to budget by $0.4 million or 13.0%

FY 2017-18: Consolidated Medical Expenses

- August 2017 MTD:
  - ➢ Actual higher than budget by $15.5 million or 5.9%
    - ▪ Medi-Cal: unfavorable variance of $14.8 million
      - MLTSS unfavorable variance of $8.5 million
        - ➢ IHSS unfavorable variance of $4.8 million
        - ➢ Nursing facilities expenses unfavorable variance of $3.5 million
      - Inpatient facilities expenses unfavorable variance of $3.6 million
      - Provider Capitation unfavorable variance of $2.0
    - OneCare Connect: unfavorable variance of $0.5 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $1.0 million

FY 2017-18: Consolidated Medical Expenses (Cont.)

- August 2017 YTD:
  - ➢ Actual higher than budget by $24.5 million or 4.7%
    - ▪ Medi-Cal: unfavorable variance of $24.6 million
      - Favorable volume variance of $5.3 million
      - Unfavorable price variance of $29.9 million
        - ➢ MLTSS expense $15.7 million higher than budget
        - ➢ Facilities $5.7 million higher than budget
        - ➢ Provider Capitation $2.6 million higher than budget
        - ➢ Pharmacy $2.6 million higher than budget
    - ▪ OneCare Connect: unfavorable variance of $0.1 million
      - Favorable volume variance of $0.7 million
      - Unfavorable price variance of $0.8 million

- Medical Loss Ratio (MLR):
  - ➢ August 2017 MTD: Actual: 97.7% Budget: 95.2%
  - ➢ August 2017 YTD: Actual: 97.7% Budget: 95.3%

Back to Agenda

FY 2017-18: Consolidated Administrative Expenses

- August 2017 MTD:
  - ➢ Actual lower than budget by $2.5 million or 20.3%
    - Salaries and Benefits: favorable variance of $0.8 million
    - Other categories: favorable variance of $1.6 million

- August 2017 YTD:
  - ➢ Actual lower than budget by $5.8 million or 24.0%
    - Salaries and Benefits: favorable variance of $1.9 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $3.9 million

- Administrative Loss Ratio (ALR):
  - ➢ August 2017 MTD: Actual: 3.4% Budget: 4.4%
  - ➢ August 2017 YTD: Actual: 3.3% Budget: 4.4%

FY 2017-18: Change in Net Assets

- August 2017 MTD:
  - $0.6 million deficit
  - $2.0 million unfavorable to budget
    - Higher than budgeted revenue of $8.7 million
    - Higher than budgeted medical expenses of $15.5 million
    - Lower than budgeted administrative expenses of $2.5 million
    - Higher than budgeted investment and other income of $2.4 million

- August 2017 YTD:
  - $0.03 million surplus
  - $2.2 million unfavorable to budget
    - Higher than budgeted revenue of $11.7 million
    - Higher than budgeted medical expenses of $24.5 million
    - Lower than budgeted administrative expenses of $5.8 million
    - Higher than budgeted investment and other income of $4.8 million

Enrollment Summary: August 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
61,748	62,241	(493)	(0.8%)	Aged	122,711	124,094	(1,383)	(1.1%)
625	618	7	1.1%	BCCTP	1,252	1,236	16	1.3%
47,149	48,756	(1,607)	(3.3%)	Disabled	94,133	97,500	(3,367)	(3.5%)
329,987	329,930	57	0.0%	TANF Child	654,519	660,002	(5,483)	(0.8%)
96,698	104,018	(7,320)	(7.0%)	TANF Adult	192,464	208,128	(15,664)	(7.5%)
3,493	3,268	225	6.9%	LTC	6,870	6,536	334	5.1%
241,455	236,166	5,289	2.2%	MCE	479,945	472,198	7,747	1.6%
781,155	**784,997**	**(3,842)**	**(0.5%)**	**Medi-Cal**	**1,551,894**	**1,569,694**	**(17,800)**	**(1.1%)**
15,229	**15,503**	**(274)**	**(1.8%)**	**OneCare Connect**	**30,594**	**30,991**	**(397)**	**(1.3%)**
221	**221**	**-**	**0.0%**	**PACE**	**436**	**437**	**(1)**	**(0.2%)**
1,386	**1,325**	**61**	**4.6%**	**OneCare**	**2,753**	**2,640**	**113**	**4.3%**
797,991	**802,046**	**(4,055)**	**(0.5%)**	**CalOptima Total**	**1,585,677**	**1,603,762**	**(18,085)**	**(1.1%)**

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Back to Agenda

Financial Highlights: August 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
797,991	802,046	(4,055)	(0.5%)	Member Months	1,585,677	1,603,762	(18,085)	(1.1%)
284,547,240	275,879,325	8,667,915	3.1%	Revenues	561,350,897	549,617,870	11,733,027	2.1%
278,134,217	262,632,565	(15,501,652)	(5.9%)	Medical Expenses	548,271,181	523,725,999	(24,545,181)	(4.7%)
9,661,211	12,121,658	2,460,446	20.3%	Administrative Expenses	18,392,974	24,209,763	5,816,789	24.0%
(3,248,189)	**1,125,102**	**(4,373,290)**	**(388.7%)**	**Operating Margin**	**(5,313,258)**	**1,682,108**	**(6,995,365)**	**(415.9%)**
2,633,276	252,544	2,380,732	942.7%	Non Operating Income (Loss)	5,343,186	505,088	4,838,098	957.9%
(614,913)	**1,377,646**	**(1,992,559)**	**(144.6%)**	**Change in Net Assets**	**29,928**	**2,187,196**	**(2,157,268)**	**(98.6%)**
97.7%	95.2%	(2.5%)		Medical Loss Ratio	97.7%	95.3%	(2.4%)	
3.4%	4.4%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
(1.1%)	0.4%	(1.5%)		Operating Margin Ratio	(0.9%)	0.3%	(1.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: August (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.8)	1.2	(4.0)	Medi-Cal	(4.7)	2.6	(7.4)
(0.5)	0.2	(0.7)	OCC	(0.9)	(0.4)	(0.5)
0.0	(0.1)	0.2	OneCare	0.0	(0.3)	0.3
0.0	(0.1)	0.1	PACE	0.4	(0.2)	0.5
(3.3)	**1.1**	**(4.4)**	**Operating**	**(5.3)**	**1.7**	**(7.0)**
2.6	0.3	2.4	Inv./Rental Inc, MCO tax	5.4	0.5	4.9
2.6	**0.3**	**2.4**	**Non-Operating**	**5.4**	**0.5**	**4.9**
(0.6)	**1.4**	**(2.0)**	**TOTAL**	**0.0**	**2.2**	**(2.2)**

Back to Agenda

Consolidated Revenue & Expense: August 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	539,700	241,455	781,155	15,229	1,386	221	797,991
REVENUES							
Capitation Revenue	$ 150,327,277	$ 103,315,440	$ 253,642,718	$ 27,626,525	$ 1,535,068	$ 1,742,929	$ 284,547,240
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	150,327,277	103,315,440	253,642,718	27,626,525	1,535,068	1,742,929	284,547,240
MEDICAL EXPENSES							
Provider Capitation	38,887,350	50,182,746	89,070,096	11,382,360	390,925	-	100,843,381
Facilities	27,764,330	19,785,152	47,549,482	3,047,055	379,430	431,796	51,407,762
Ancillary	-	-	-	737,987	50,680	-	788,667
Skilled Nursing	-	-	-	-	20,532	-	20,532
Professional Claims	5,433,906	8,024,702	13,458,608	-	-	384,026	13,842,634
Prescription Drugs	18,199,847	19,041,545	37,241,392	5,212,857	561,978	128,743	43,144,970
Long-term Care Facility Payments	55,304,866	2,366,672	57,671,538	4,872,269	-	27,961	62,571,767
Medical Management	2,034,983	946,460	2,981,443	1,135,771	11,685	393,206	4,522,105
Reinsurance & Other	429,574	158,626	588,200	168,246	5,408	230,544	992,398
Total Medical Expenses	148,054,855	100,505,902	248,560,758	26,556,546	1,420,637	1,596,276	278,134,217
Medical Loss Ratio	**98.5%**	**97.3%**	**98.0%**	**96.1%**	**92.5%**	**91.6%**	**97.7%**
GROSS MARGIN	**2,272,422**	**2,809,538**	**5,081,960**	**1,069,980**	**114,431**	**146,652**	**6,413,023**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,386,053	762,105	26,871	75,577	6,250,606
Professional fees			215,842	501	0	4,548	220,891
Purchased services			864,750	84,426	15,356	320	964,852
Printing and Postage			247,873	52,460	3,608	4,712	308,653
Depreciation and Amortization			378,999	-	-	2,168	381,167
Other expenses			1,062,310	80,580	(0)	27,293	1,170,183
Indirect cost allocation, Occupancy expense			(254,222)	584,428	31,910	2,744	364,860
Total Administrative Expenses			7,901,605	1,564,499	77,746	117,362	9,661,211
Admin Loss Ratio			**3.1%**	**5.7%**	**5.1%**	**6.7%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(2,819,645)	(494,519)	36,685	29,290	(3,248,189)
INVESTMENT INCOME			-	-	-	-	2,645,171
NET RENTAL INCOME			-	-	-	-	3,470
NET GRANT INCOME			(15,651)	-	-	-	(15,651)
OTHER INCOME			286	-	-	-	286
CHANGE IN NET ASSETS			**$ (2,835,010)**	**$ (494,519)**	**$ 36,685**	**$ 29,290**	**$ (614,913)**
BUDGETED CHANGE IN ASSETS			1,172,168	156,700	(124,254)	(79,512)	1,377,646
VARIANCE TO BUDGET - FAV (UNFAV)			(4,007,178)	(651,219)	160,940	108,802	(1,992,559)

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Back to Agenda

Consolidated Revenue & Expense: August 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,071,949	479,945	1,551,894	30,594	2,753	436	1,585,677
REVENUES							
Capitation Revenue	$ 297,475,529	$ 204,627,244	$ 502,102,773	$ 53,119,395	2,883,642	$ 3,245,086	$ 561,350,897
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	297,475,529	204,627,244	502,102,773	53,119,395	2,883,642	3,245,086	561,350,897
MEDICAL EXPENSES							
Provider Capitation	77,139,805	99,994,753	177,134,558	21,228,884	791,386	-	199,154,828
Facilities	51,854,341	40,673,489	92,527,830	5,527,518	774,392	634,161	99,463,901
Ancillary	-	-	-	1,322,722	82,195	-	1,404,917
Skilled Nursing	-	-	-	-	47,799	-	47,799
Professional Claims	12,618,448	16,097,334	28,715,782	-	-	627,722	29,343,504
Prescription Drugs	35,893,148	37,480,574	73,373,722	10,246,598	987,121	222,205	84,829,645
Long-term Care Facility Payments	108,474,130	4,857,605	113,331,735	10,103,748	-	16,758	123,452,240
Medical Management	4,698,710	1,092,994	5,791,704	2,200,090	39,978	726,748	8,758,520
Reinsurance & Other	649,793	278,049	927,842	428,558	14,072	445,354	1,815,825
Total Medical Expenses	291,328,374	200,474,798	491,803,172	51,058,117	2,736,943	2,672,949	548,271,181
Medical Loss Ratio	**97.9%**	**98.0%**	**97.9%**	**96.1%**	**94.9%**	**82.4%**	**97.7%**
GROSS MARGIN	**6,147,155**	**4,152,446**	**10,299,601**	**2,061,278**	**146,699**	**572,138**	**13,079,716**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			10,361,343	1,490,688	54,576	147,268	12,053,876
Professional fees			388,187	501	0	6,105	394,792
Purchased services			1,473,279	173,766	26,091	6,178	1,679,313
Printing and Postage			415,473	65,258	10,050	4,927	495,707
Depreciation and Amortization			754,994	-	-	4,264	759,259
Other expenses			2,163,989	109,967	(0)	31,168	2,305,124
Indirect cost allocation, Occupancy expense			(533,235)	1,168,856	63,820	5,462	704,903
Total Administrative Expenses			15,024,030	3,009,035	154,537	205,372	18,392,974
Admin Loss Ratio			**3.0%**	**5.7%**	**5.4%**	**6.3%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(4,724,429)	(947,757)	(7,838)	366,766	(5,313,258)
INVESTMENT INCOME			-	-	-	-	5,354,504
NET RENTAL INCOME			-	-	-	-	6,640
NET GRANT INCOME			(18,317)	-	-	-	(18,317)
OTHER INCOME			359	-	-	-	359
CHANGE IN NET ASSETS			**$ (4,742,387)**	**$ (947,757)**	**$ (7,838)**	**$ 366,766**	**$ 29,928**
BUDGETED CHANGE IN ASSETS			2,615,212	(437,305)	(343,829)	(151,970)	2,187,196
VARIANCE TO BUDGET - FAV (UNFAV)			(7,357,599)	(510,452)	335,991	518,736	(2,157,268)

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Back to Agenda

Balance Sheet:
As of August 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$693,594,087	Accounts payable	$28,940,352
	Investments	983,493,588	Medical claims liability	1,105,506,963
	Capitation receivable	309,923,565	Accrued payroll liabilities	11,054,769
	Receivables - Other	21,725,557	Deferred revenue	124,648,060
	Prepaid Expenses	5,768,570	Deferred lease obligations	184,405
			Capitation and withholds	586,805,387
	Total Current Assets	**2,014,505,367**	**Total Current Liabilities**	**1,857,139,935**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability	28,932,498
	Leasehold improvements	6,148,441		
	505 City Parkway West	49,422,364	Net Pension Liabilities	16,212,231
		89,008,717	Long Term Liabilities	100,000
	Less: accumulated depreciation	(35,622,495)		
	Capital assets, net	**53,386,222**	**TOTAL LIABILITIES**	**1,902,384,664**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings	-
			Deferred inflows of Resources - Changes in Assumptions	1,340,010
	Board-designated assets			
	Cash and cash equivalents	28,937,963	Tangible net equity (TNE)	91,440,932
	Long term investments	508,506,303	Funds in excess of TNE	622,047,388
	Total Board-designated Assets	537,444,266		
	Total Other Assets	**537,744,266**	**Net Assets**	**713,488,320**
	Deferred outflows of Resources - Pension Contributions	5,234,198		
	Deferred outflows of Resources - Difference in Experience	1,072,771		
	Deferred outflows of Resources - Excess Earnings	5,270,171		
TOTAL ASSETS & OUTFLOWS		**2,617,212,995**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,617,212,995**

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Back to Agenda

Board Designated Reserve and TNE Analysis
As of August 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,822,740				
	Tier 1 - Logan Circle	146,507,294				
	Tier 1 - Wells Capital	146,597,541				
Board-designated Reserve		439,927,574	311,866,164	484,712,063	128,061,410	(44,784,488)
TNE Requirement	Tier 2 - Logan Circle	97,516,691	91,440,932	91,440,932	6,075,759	6,075,759
	Consolidated:	537,444,266	403,307,097	576,152,995	134,137,169	(38,708,730)
	Current reserve level	*1.87*	*1.40*	*2.00*		

Back to Agenda

HN Enrollment Summary - Medi-Cal

Health Network Name	SEPTEMBER 2017	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	151,835	19.5%	22.6%
Monarch Family HealthCare (HMO16)	85,923	11.0%	12.8%
CalOptima Community Network (CN)	74,168	9.5%	11.0%
Arta Western Health Network (SRG66)	69,176	8.9%	10.3%
Family Choice Health Network (PHC21)	47,555	6.1%	7.1%
Kaiser Permanente (HMO04)	46,161	5.9%	6.9%
Alta Med Health Services (SRG69)	45,481	5.8%	6.8%
Prospect Medical Group (HMO17)	34,959	4.5%	5.2%
United Care Medical Network (SRG67)	34,600	4.4%	5.1%
Noble Mid-Orange County (SRG64)	29,978	3.8%	4.5%
Talbert Medical Group (SRG65)	23,654	3.0%	3.5%
AMVI Care Health Network (PHC58)	23,233	3.0%	3.5%
Heritage - Regal Medical Group (HMO15)	4,966	0.6%	0.7%
OC Advantage (PHC35)	1,571	0.2%	0.2%
Total Health Network Capitated Enrollment	**673,259**	**86.4%**	**100.0%**
CalOptima Direct (all others)	105,703	13.6%	
Total Medi-Cal Enrollment	**778,962**	**100.0%**	

Back to Agenda

HN Enrollment Summary – OneCare Connect

Health Network Name	SEPTEMBER 2017	Percentage
Monarch HealthCare (HMO16DB)	4,857	31.8%
Propect Medical Group (HMO17DB)	2,844	18.6%
Family Choice Medical Group (SRG81DB)	1,860	12.2%
CalOptima Community Network (CN)	1,726	11.3%
Talbert Medical Group (SRG52DB)	1,142	7.5%
Arta Western Health Network(SRG66DB)	529	3.5%
United Care Medical Group (SRG67DB)	524	3.4%
Alta-Med (SRG69DB)	524	3.4%
AMVI Care Health Network (PHC58DB)	477	3.1%
Noble Mid Orange County (SRG64DB)	450	2.9%
Heritage - Regal Medical Group (HMO15)	221	1.4%
OC Advantage (PHC35DB)	111	0.7%
Total OneCare Connect Enrollment	**15,265**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	SEPTEMBER 2017	Percentage
Monarch HealthCare (PMG53DE)	727	51.5%
AMVI/Prospect Medical Group (PMG27DE)	325	23.0%
Talbert Medical Group (PMG52DE)	109	7.7%
Family Choice Medical Group (PMG21DE)	92	6.5%
Arta Western Health Network (PMG66DE)	65	4.6%
Alta-Med (PMG69DE)	46	3.3%
United Care Medical Group (PMG67DE)	33	2.3%
Noble Mid Orange County (PMG64DE)	16	1.1%
Total OneCare Enrollment	**1,413**	**100.0%**

Back to Agenda

Children's Health Insurance Program (CHIP) in Orange County

Introduction

The Children's Health Insurance Program (CHIP) is a joint federal-state program established to provide coverage for children 19 and under in families whose incomes are too high to qualify for Medicaid. Children who are covered through CHIP have access to a variety of health care services, including primary care, emergency services, immunizations, and dental care. Today, CHIP has an annual budget of $15 billion and provides health coverage for approximately 8.4 million children nationwide. Similar to Medicaid, CHIP is funded jointly by federal and state dollars with each state administering its own program. However, unlike mandatory Medicaid funding, which is open-ended based on the number of enrollees, federal CHIP funding is discretionary which means it must be periodically approved by Congress.

The most recent CHIP re-authorization was signed into law in 2015, which funded CHIP through September 30, 2017. However, according to the Medicaid and CHIP Payment Access Commission (MACPAC), a federal non-partisan health policy agency, California is expected to fully exhaust its CHIP funds by December 2017. Additionally, it is unclear how long CHIP will be re-authorized and how much of the program will be federally funded. This brief highlights the history and importance of CHIP, and outlines how potential changes to the program could affect Orange County.

Federal Enactment of CHIP

CHIP was first authorized 20 years ago through the Balanced Budget Act of 1997 (H.R. 2015, Kasich). The bipartisan legislation passed the House by a vote of 346-85, passed the Senate by a vote of 85-15, and was signed by President Clinton on August 5, 1997. The bill authorized $40 billion over 10 years in new federal spending for CHIP.

CHIP's authorizing legislation established a block grant funding formula designed to incentivize states by using an enhanced federal medical assistance percentage (E-FMAP). The CHIP E-FMAP calculates each state's traditional Medicaid FMAP, ranging from 50 – 74 percent, and enhances it up to a range of 65 – 81.5 percent. States are then required to fund the remainder of the program and provide health insurance coverage to children whose family income is higher than the traditional Medicaid eligibility ceiling. This block grant funding formula has required states to rely on Congressional re-authorization of CHIP to ensure its continuation at the state level.

When federal CHIP funding was set to expire in 2007, President Bush signed a temporary CHIP re-authorization on December 29, 2007 through the Medicare, Medicaid, and SCHIP Extension Act (S 2499, Baucus), which extended existing CHIP funding through March 31, 2009. Then on February 4, 2009, President Obama signed the CHIP Re-authorization Act (CHIPRA) of 2009 (H.R. 2, Pallone) into law, which added $33 billion in federal funding for CHIP through FFY 2013.

CHIPRA allowed children and pregnant women who are newly qualified immigrants (NQIs) to access CHIP. However, when CHIPRA was signed into law, California was already providing CHIP coverage to NQI children and pregnant women using 100 percent state funding. In this case, CHIPRA allowed the state to begin receiving federal funding for providing CHIP coverage for NQIs. CHIPRA also expanded dental and mental health parity benefits, and established MACPAC to advise Congress on Medicaid and CHIP policy. CBO estimated that CHIPRA would result in approximately 4.1 million fewer uninsured children by 2013.

CHIP in California

After CHIP was approved at the federal level, California established its statewide CHIP called the Healthy Families Program (HFP) beginning in July 1, 1998. HFP, funded at the 65/35 CHIP E-FMAP, allowed both public and commercial managed care plans to provide CHIP coverage to children between 101 – 250 percent of the FPL. HFP also required enrollees with family incomes of 160 percent of the FPL or above to pay monthly premiums for coverage. Statewide HFP enrollment reached a high of 1.6 million enrollees, making it the largest state CHIP in the nation. CalOptima participated in HFP, along with four other Orange County health maintenance organization (HMO) plans (Anthem Blue Cross, Blue Shield, Health Net, and Kaiser Permanente). By 2012, CalOptima's HFP enrollment was approximately 38,000 children out of approximately 81,000 total HFP members in Orange County.

CHIP and the ACA

When the Affordable Care Act (ACA) was signed into law on March 23, 2010, it brought about significant changes at the federal, state, and county levels. At the federal level, the ACA extended existing federal CHIP funding for an additional two years, through federal fiscal year (FFY) 2015. The ACA also established the CHIP maintenance of effort

(MOE) through FFY 19, which required states to maintain income eligibility levels for CHIP and further enhanced future federal CHIP funding. Beginning October 1, 2015, the MOE increased CHIP's E-FMAP by an additional 23 percent for FFYs 2016-19. This brought federal CHIP funding to a range of 88 – 100 percent, even though the ACA only authorized federal CHIP funds through FFY 15 at the traditional CHIP E-FMAP.

At the state level, Governor Brown signed Assembly Bill (AB) 1494 (2012-13 California Budget Act). This bill included a provision that eliminated HFP beginning in January 2013, and gradually transitioned approximately 875,000 HFP members to Medi-Cal over the course of one year. This statewide change effectively transitioned California's separate CHIP (HFP) to a combination CHIP Medicaid expansion program. Due to the ACA's CHIP MOE that requires states to maintain CHIP eligibility, if federal CHIP funds expire, California would be required to continue providing health care services for CHIP-eligible children funded at the traditional 50/50 Medicaid FMAP instead of the CHIP E-FMAP.

During this transition from a separate state CHIP to a combination Medicaid expansion CHIP, HFP members whose family income was at or below 250 percent of the FPL were enrolled in the Optional Targeted Low Income Children's Program (OTLICP) with an eligibility ceiling at 266 percent of the FPL. Today, OTLICP enrollees whose family incomes are over 160 percent of the FPL must continue to pay monthly premiums for coverage, which are $13 per child and not exceeding $39 for a family with three or more children.

At the county level, these federal and state changes positioned CalOptima as the health plan responsible for providing health care services for nearly all of Orange County's CHIP population, since CalOptima is the county organized health system (COHS) and sole Medi-Cal plan in Orange County. Today, CalOptima's CHIP enrollment is approximately 112,000 (30 percent of all members under the age of 19 and 15 percent of CalOptima's total membership).

Recent Federal and State CHIP Actions

With CHIP's federal funding set to expire again in 2015, President Obama signed the bipartisan Medicare Access and CHIP Re-authorization Act (MACRA) of 2015 (H.R. 2, Burgess) into law. MACRA retained the ACA's CHIP MOE, authorized the ACA's 23 percent increase in federal CHIP funding, and extended CHIP funding for an additional two years (through FFY 17). This means that while CHIP is authorized until September 30, 2019 due to the passage of the ACA, federal funding for the program expired on September 30, 2017 due to the expiration of CHIP funds in MACRA. The House Committee on Energy and Commerce and the Senate Committee on Finance have recently held hearings and advanced separate legislation to re-authorize CHIP funding, but there has yet to be a final agreement by both chambers.

California's current CHIP enrollment is approximately 1.2 million and its annual budget is approximately $3.2 billion – 88 percent of which has been federally funded for FFYs 16 and 17. However, Congressional CHIP re-authorization will ultimately determine the future cost to states and health plans such as CalOptima. The 2017-18 California Budget Act includes approximately $536 million in additional state funding, due to the state's expectation that federal CHIP funding will revert back to pre-ACA levels of 65/35. However, uncertainty for the future of CHIP remains.

Next Steps for CHIP

Since CHIP was first authorized 20 years ago, the program has been re-authorized four times with bipartisan support from both Congress and the Administration. According to the Children's Hospital Association, CHIP, along with Medicaid, has successfully brought the rate of uninsured children to an all-time low, with 95 percent of all children insured. California's CHIP income eligibility ceiling is currently at 266 percent of the FPL, which translates to a family of four with an annual income at or below approximately $65,000. In Orange County, CHIP allows approximately 112,000 children of working families who are living slightly above the federal poverty level the ability to access high quality, cost-effective health care.

Since CalOptima assumed responsibility for Orange County's CHIP population, CalOptima has been ranked by the National Committee for Quality Assurance (NCQA) as California's top Medi-Cal plan for four consecutive years. CalOptima also has one of the lowest administrative cost ratios in California, with 96 cents of every dollar going to pay local, private sector providers to provide health care services to our members. CalOptima recognizes the importance of providing Orange County's low-income children with access to quality health care services, and remains concerned with the expiration of federal funding for CHIP. To that end, the CalOptima Chairman of the Board of Directors authored a letter on June 16, 2017 to the Orange County Congressional delegation expressing strong support for CHIP re-authorization.

If CHIP is not re-authorized, it could result in a significant cost shift to states, potentially putting children and families at risk of losing access to affordable care. CalOptima stands ready to work with lawmakers, our provider partners, and local stakeholders to ensure the continuation of CHIP and its vital role in providing care for children in our community.

Back to Agenda

CHIP Legislative Timeline

Date – Legislative Action	Impact
August 5, 1997 – The Balanced Budget Act of 1997 (H.R. 2015, Kasich) is signed into law by President Clinton	• Authorizes CHIP • Approves $40 billion in federal CHIP funds over 10-year period • Established CHIP E-FMAP (65/35 for California)
October 3, 1997 – Three California state bills (SB 903, AB 1126, and AB 1572) are signed into law by Governor Davis	• Authorizes California's state CHIP know as the Healthy Families Program • Both commercial and public plans, including CalOptima, begin enrolling members on July 1, 1998
December 29, 2007 – The Medicare, Medicaid, and SCHIP Extension Act of 2007 (S 2499, Baucus) is signed into law by President Bush	• Extended existing federal CHIP funding through 3/31/2009
February 4, 2009 – The CHIP RE-authorization Act (CHIPRA) of 2009 (H.R. 2, Pallone) is signed into law by President Obama	• Extended CHIP funding through FFY 13 • Added $33 billion to CHIP • Allowed states to enroll NQIs • Expanded dental and mental health parity benefits • Established MACPAC
March 23, 2010 – The Affordable Care Act (H.R. 3590, Rangel) is signed into law by President Obama	• Extended CHIP funding through FFY 15 • Established CHIP MOE through FFY 19, which requires states to maintain CHIP eligibility levels • Further enhanced CHIP E-FMAP by 23 percent from FFY 16-19
June 27, 2012 – AB 1494 is signed into law by Governor Brown	• Beginning January 1, 2013, transitioned 875,000 HFP enrollees to Medi-Cal
April 16, 2015 – The Medicare Access and CHIP Re-authorization Act (MACRA) of 2015 (H.R. 2, Burgess) is signed into law by President Obama	• Extended CHIP funding through FFY 17 • Retained the ACA's CHIP MOE through FFY 19 • Allowed the ACA's 23 percent CHIP E-FMAP increase to go into effect 10/1/15 (88/12 for California)
September 30, 2017 – Federal CHIP funding expired	• Congressional action (or other short-term solution by the Administration) required for federal CHIP funding to continue

Endnotes

[1] MACPAC; "Federal CHIP Funding: When Will States Exhaust Allotments?" March, 2017
[2] California Health Care Foundation, CHIP Reauthorization: Analysis of Policy Changes for Healthy Families. January 28, 2010
[3] National Academy for State Health Policy, California 2016 CHIP Fact Sheet.
[4] CRS. "State Health Insurance Program: An Overview" March 20, 2015
[5] Children's Hospital Association. "Extend CHIP Now", August 2017

Back to Agenda

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 Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), and Program of All-Inclusive Care for the Elderly (PACE).

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Verbal Update on Referral to County Mental Health Plan

Provider Advisory Committee

October 12, 2017

Edwin Poon, PhD

Director of Behavioral Health Services

Back to Agenda

Whole Child Model

Provider Advisory Committee

October 12, 2017

Candice Gomez

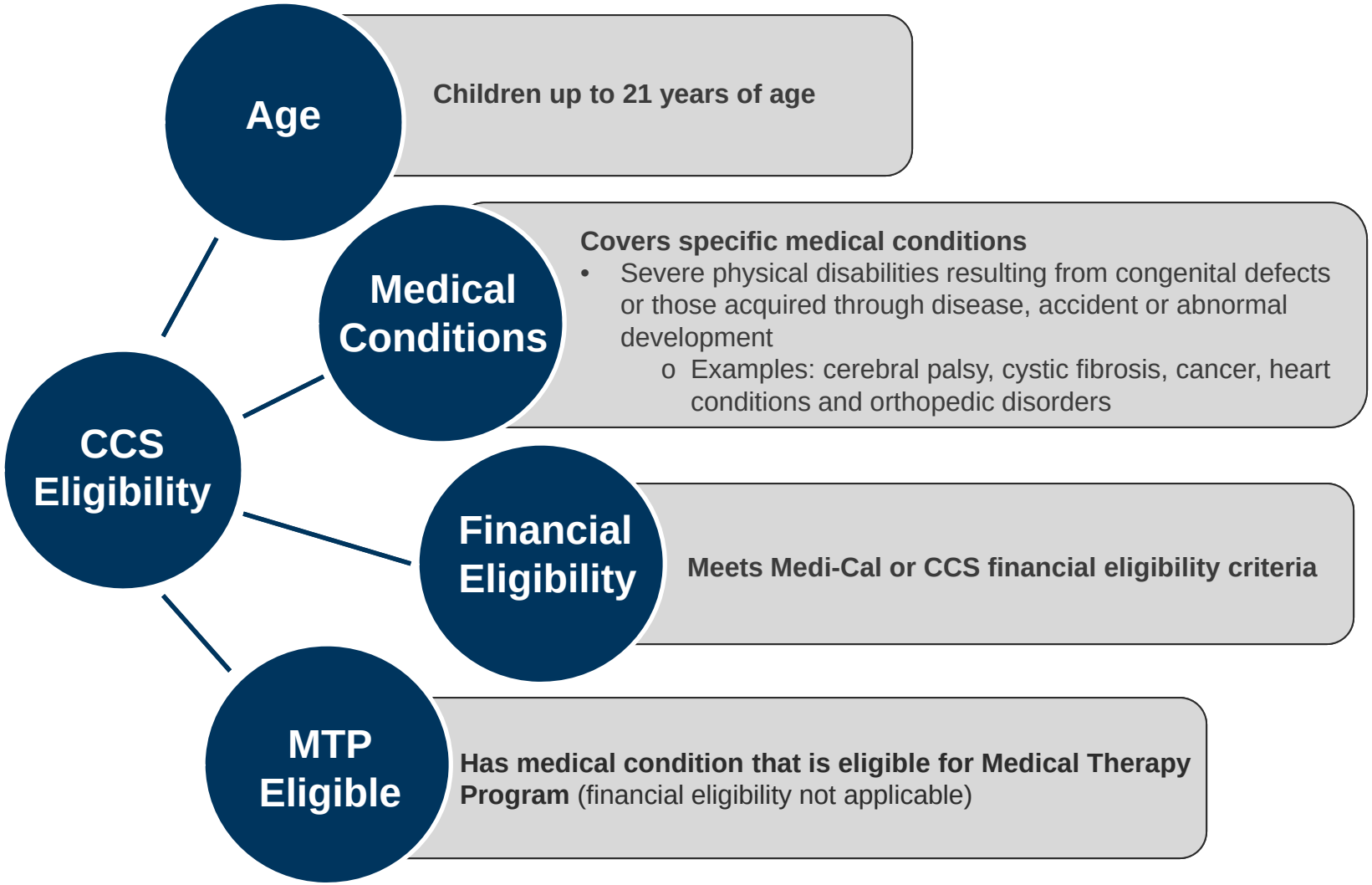
Executive Director, Business Integration

Back to Agenda

CCS Background

- California Children's Services (CCS) is a statewide program providing medical care, case management, physical/occupational therapy and financial assistance for children meeting eligibility criteria.
  - Services carved out of most Medi-Cal managed care plans (MCP), including CalOptima
  - Orange County Health Care Agency (OCHCA) is responsible for CCS services for approximately 13,000 children enrolled in CalOptima

CCS Eligibility Criteria



Back to Agenda

Whole Child Model

- On September 25, 2016, Gov. Brown signed Senate Bill 586 authorizing CCS integration as a Medi-Cal managed care plan (MCP) benefit.
  - Intent is to improve coordination of services to meet the needs of the whole child, not just address the CCS-eligible condition
  - Effective in select counties, including Orange County
  - Integration is no sooner than July 1, 2018
  - Per Department of Health Care Services (DHCS) schedule, CalOptima is scheduled to implement no sooner than January 1, 2019
  - Responsibilities for eligibility determination and Medical Therapy Program remain unchanged under the Whole Child Model (WCM)

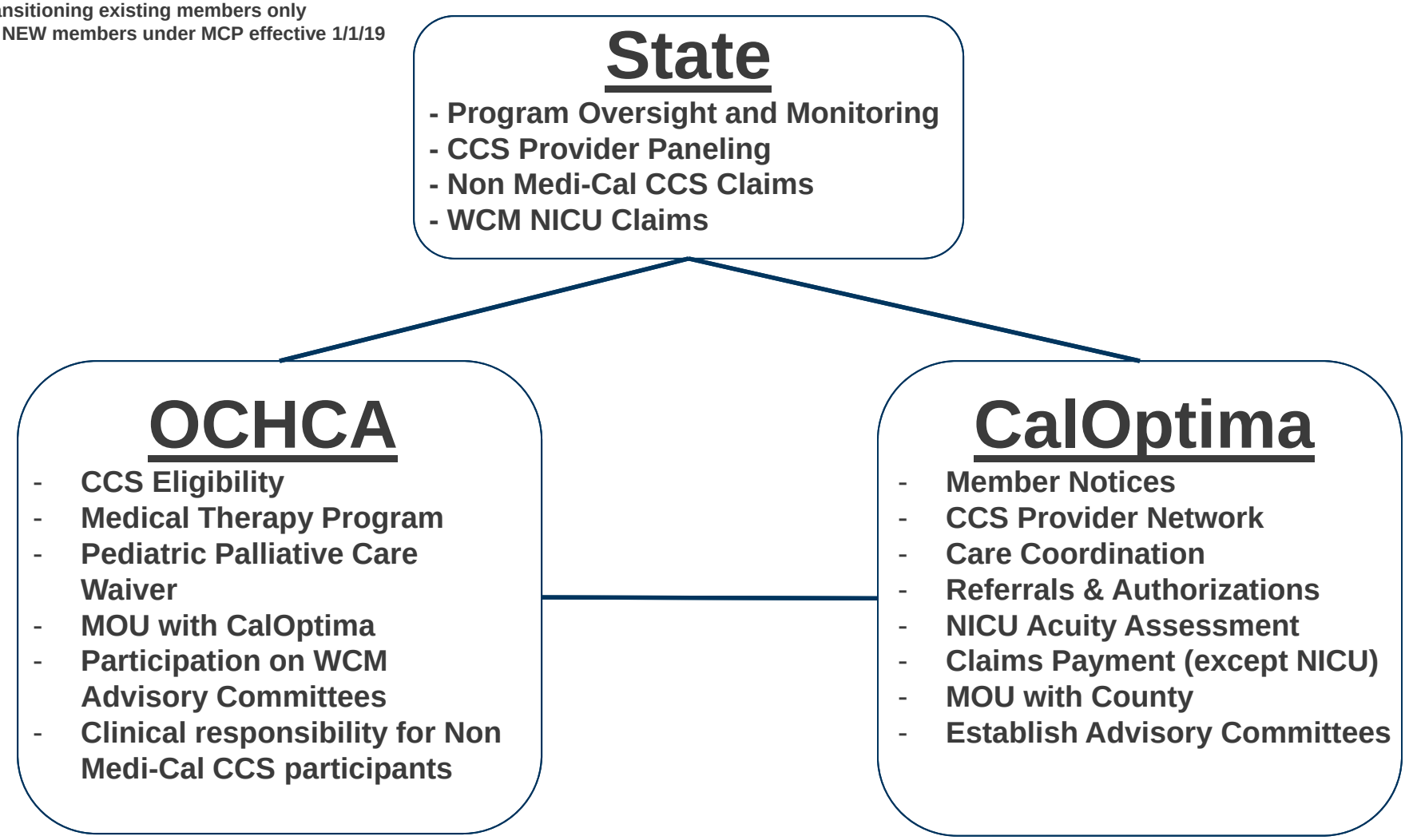
State Goals for WCM

- Implement patient and family centered approach.
- Improve care coordination through an organized delivery system.
- Maintain quality.
- Streamline care delivery.
- Build on lessons learned
- Cost-effective

Back to Agenda

Legislative Structure Effective 1/1/19

- Transitioning existing members only
- All NEW members under MCP effective 1/1/19



Back to Agenda

CalOptima Guiding Principles

CCS Children

Continuity of care

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

Integration of services

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

Member choice

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

Timely access

- Children receive timely authorizations and appointments with specialists.

CCS Providers

Broad participation

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

Administrative simplification

- Fewer agencies and policies mean less fragmentation.

Stable payments

- Providers receive 140 percent for CCS specialty care.

CCS Community

Thoughtful approach

- CalOptima shows careful consideration and ample planning to minimize disruption in the community from the CCS transition.

Collaboration

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

CalOptima Demographics

- **In Orange County, approximately 13,000 children are enrolled in CCS**
  - ➢ **90 percent are CalOptima members**

Languages	Cities
• Spanish = 48% • English = 44% • Vietnamese = 4% • Unknown = 3%	• Santa Ana = 23% • Anaheim = 18% • Garden Grove = 8% • Orange = 6% • Fullerton = 4%

Back to Agenda

Membership by Health Network

Health Network	Percent*
AltaMed Health Services	3.47%
AMVI Care Health Network	1.41%
Arta Western Health Network	6.93%
COD Administrative	2.26%
COD Community Network	7.35%
CHOC Health Alliance	50.94%
Family Choice Health Network	2.92%
HPN — Regal Medical Group	0.15%
Kaiser Permanente	7.64%
Monarch Family HealthCare	7.90%
Noble Mid-Orange County	2.46%
OC Advantage	0.04%
Prospect Medical Group	1.97%
Talbert Medical Group	1.72%
United Care Medical Group	2.85%

*Data as of 9/6/2017

Back to Agenda

Key Components

- Continuity of Care
  - May stay with their county public health nurse for care management and care coordination
  - Special provisions for durable medical equipment (DME) and pharmacy benefits
- Establish family and clinical advisory committees
- Prior to go-live, provide 90, 60 and 30 day written notices to all CCS members
- Upon transition, perform risk assessments for children receiving WCM services
- Continue grievances and appeals process for WCM transition-related requests

WCM Family Advisory Committee

- Purpose is to provide input and recommendations to CalOptima
- Proposed committee structure
  - Stand-alone committee reporting to the CalOptima Board
  - 10 seats
    - 8 seats: Parent, authorized representative, member aged 18 or older
    - 2 seats: Community-based organizations
- Considering November Board action
- Targeting April/May 2018 for first meeting

Back to Agenda

WCM Clinical Advisory Committee

- Purpose is to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisors on other clinical issues relating to CCS conditions
- Must include:
  - CalOptima's chief medical officer or equivalent
  - County CCS medical director
  - At least 4 CCS-paneled providers
- Targeting August 2018

Back to Agenda

Ongoing Activities

- Monitoring state guidance
- Participating in state-sponsored meetings and workshops
- Analyzing data and information available on current CCS program
- Evaluating WCM transition impacts
- Assessing care delivery models to meet WCM goals
- Forming advisory committees

Resources

- Senate Bill 586
  - http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
- California Department of Health Care Services (DHCS)
  - http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
- CalOptima Whole Child Model webpage
  - https://www.caloptima.org/en/CCS_Info.aspx

CalOptima's Mission

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

Back to Agenda

Back to Agenda