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

THURSDAY, FEBRUARY 8, 2018
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 December 14, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

IV. PUBLIC COMMENT
At this time, members of the public may address the Committee on general topics. Public Comment on posted item(s) will follow staff presentation of the item(s) to the Committee. If you wish to speak on an item contained in the agenda, please complete a Public Comment Request Form(s) identifying the item(s) and submit the form to the assistant to the 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. Tele Health Presentation
B. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

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MINUTES

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

December 14, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 14, 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 8:10 a.m., and Member Dr. Orras led the Pledge of Allegiance.

ESTABLISH QUORUM

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

Members Absent: Theodore Caliendo, M.D.; Mary Hale; Pamela Kahn, R.N.;

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Greg Hamblin, Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the Provider Advisory Committee

The PAC observed a moment of silence in memory of Member Alan Edwards, M.D., who passed away in November. Dr. Edwards represented the Orange County Health Care Agency on the PAC for 11 years.

MINUTES

Approve the Minutes of the November 9, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Dr. Sweidan, seconded and carried, the Committee approved the minutes of the November 9, 2017 meeting. (Motion carried 12-0-0; Members Caliendo, Hale and Kahn absent)***

PUBLIC COMMENTS

No requests for public comment were received.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, explained how the California Children's Services (CCS) Whole Child Model (WCM) is a high priority for CalOptima during the upcoming year and that a stakeholder meeting would be held on January 25, 2018 to discuss CalOptima's implementation plan for the WCM. Mr. Schrader noted that CalOptima has been scheduled for phase two of the State-wide implementation by the Department of Healthcare Services (DHCS) for the County Organized Health Systems. He also noted that more stakeholder meetings will be held throughout the year to prepare for the January 1, 2019 implementation.

Chief Operating Officer Update

Ladan Khamseh, Chief Operations Officer, discussed the outreach to members who were eligible for Medicare Part A through Social Services. Ms. Khamseh also provided an update on the behavioral health transition as it relates to provider contracting. She noted that some providers had not return their signed contract before the deadline and members had been notified that they would have to switch providers. She also noted that once the signed contracts were received, the Customer Service team had been pro-active in reaching out to the approximately 1300 members to let them know that they could continue to see their current providers. Mr. Schrader also noted that an orientation for newly-contracted behavioral health providers is scheduled for December 20, 2017.

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, reported on Senate Bill 1004, which requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure the delivery of palliative care services by Managed Care Plans. Dr. Helmer noted that CalOptima and its contracted health networks will be responsible for providing palliative care services to Medi-Cal members effective January 1, 2018. CalOptima anticipates receiving additional final guidance from DHCS before the implementation date

Chair Miranti reordered the agenda to hear Information Item B, Opioid Epidemic Update.

Opioid Epidemic Update

Richard Bock, M.D., Deputy Chief Medical Officer, presented an update on the current state of the opioid epidemic and its impact on Orange County, and CalOptima's role in helping reduce the number of CalOptima members addicted to opioids including formulary restrictions, Pharmacy Home Program, outreach to the highest Morphine Equivalent Dose (MED) prescribers and quality measures.

Chief Financial Officer Update

Greg Hamblin, Chief Financial Officer, presented the October 2017 financial report, and summarized CalOptima's financial performance and current reserve levels. Mr. Hamblin also reviewed the Health Network enrollment figures for the same period.

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Network Operation Update
Michelle Laughlin, Executive Director Network Operations, provided an update on the behavioral health transition, and noted that DHCS has certified CalOptima's behavioral health provider network. Ms. Laughlin reported on staff's recent site visit at the Inland Empire Health Plan (IEHP). IEHP shared their best practices including a center of excellence for autism screening

Federal and State Budget Update
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided an update on the State and Federal budgets, including the re-authorization of Children's Health Insurance Program (CHIP) funding, cost-sharing for the Exchanges, and the current state of the tax reform bill.

INFORMATION ITEMS

Optometry's Role in Patient Care
PAC Member John Nishimoto, OD, presented an overview of Optometry's role in patient care including early detection and intervention, and diabetic retinal exams. Dr. Nishimoto noted that approximately 64% of CalOptima members received retinal/eye exams in 2015.

PAC Member Updates
Chair Miranti solicited volunteers for a joint ad hoc of the Member Advisory Committee (MAC) and the OneCare Connect MAC to develop the agenda for the joint MAC, OCC MAC and PAC meeting scheduled on March 8, 2018. Members Pimentel, Orras and Myers agreed to participate with Chair Miranti on the ad hoc. The joint ad hoc meeting is scheduled on January 11, 2018.

ADJOURNMENT
There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:01 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: February 8, 2018

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MEMORANDUM

DATE:	February 1, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Behavioral Health Transition
Effective January 1, CalOptima assumed responsibility for administering Medi-Cal behavioral health benefits for members. CalOptima's successful efforts to contract with hundreds of providers offering mental health and Applied Behavior Analysis services ensured that the vast majority of members were able to continue seeing their existing providers. Fewer than 300 members requested continuity of care arrangements. Under a continuity of care arrangement, a member may continue to see the same provider for up to a year if the provider agrees to accept the standard rate through a member-specific Letter of Agreement. Further, CalOptima has hired nearly all the necessary clinical and customer service staff needed to administer the behavioral health benefits and looks forward to the opportunity to better coordinate physical and mental health, which can improve outcomes for members.

Children's Health Insurance Program (CHIP)
On January 22, Congress reauthorized six years of funding for CHIP. This is good news for approximately 112,000 of our Medi-Cal members who are eligible because of CHIP, which provides coverage for children age 0–19 whose parents earn up to 266 percent of the federal poverty level. Prior to this decision, as part of the Affordable Care Act (ACA), California was required to maintain CHIP eligibility levels and enrollment through 2019 in what's known as a maintenance of effort provision. Therefore, the lapse in federal funding would not have caused our members to lose eligibility, but it could have caused budget concerns at the state level.

Continuing Resolution (CR)
The important reauthorization of CHIP was part of a larger CR that funds the federal government through February 8. The CR specifies that, in the short term, funding for Medicare and CHIP will continue without disruption. Regarding Medicaid, states already have sufficient funding through the second quarter. In the event of another government shutdown, the U.S. Department of Health & Human Services has a contingency plan that covers all three public health programs.

State Budget Proposal
On January 10, Gov. Brown released his proposed FY 2018–19 state budget, which starts on July 1, 2018. Given California's positive fiscal outlook, the budget includes a $6.2 billion surplus that the governor plans to put into reserves. Spending for Medi-Cal in FY 2018–19 will be relatively stable, with a total budget of $101.5 billion, which correlates to a flat statewide enrollment

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projection of 13.5 million beneficiaries. When releasing his budget proposal, Gov. Brown acknowledged that it does not account for the potential impact of federal actions on health care, such as the recent passage of the tax bill or future efforts affecting ACA. Hearings on the budget proposal will take place during the next few months, followed by the release of the May Revision, which will consider any federal changes to health care programs and an updated financial picture based on April tax returns and 2019 federal tax law.

Medi-Cal Rates

Alongside the state budgeting process, the Department of Health Care Services (DHCS) follows a routine rate-setting process for Medi-Cal. For FY 2018–19, we expect draft rates for both our Classic and Expansion populations by May. Historically, the state has been paying managed care plans more for Expansion members that gained coverage through the ACA even though their health needs and utilization of services are similar to the Classic population. More recently, the state has been gradually adjusting those rates downward, and CalOptima has been passing on the reduction to providers. We anticipate this will be the case for FY 2018–19, and we have been notifying health networks accordingly. Specific guidance is not yet available. However, Medi-Cal health plan financial leaders across the state expect the Expansion rate to be similar to the Classic rate for adult Temporary Assistance for Needy Families (TANF) members. To prepare for the next fiscal year, we have informed health networks that they may want to develop their budgets with this assumption in mind.

Proposition 56 Revenue

While a reduction to Expansion rates is expected for the upcoming fiscal year, Medi-Cal providers can anticipate retroactive supplemental payments for certain services rendered in this fiscal year. Due to the Proposition 56 tobacco tax approved by voters in 2016, California is collecting $2 more in taxes on each pack of cigarettes. Recently, DHCS provided CalOptima with an estimate of add-on capitation, which we will pay to providers based on specific procedure codes used by primary care physicians and psychiatrists. Tobacco tax dollars are also boosting benefits and reimbursement in Denti-Cal. Starting in 2018, the program restored services for adults that were previously eliminated and raised rates for dentists by 40 percent.

Medical Loss Ratio (MLR) Audit

In January, DHCS released final instructions and data templates for the MLR audit of Medi-Cal Expansion. Importantly, the regulator clarified that all capitation payments made by a contractor to delegated entities for Expansion members are attributable to services and considered allowed medical expenses. This is consistent with how CalOptima records medical expenses. The MLR corridor amounts were also announced: MLR less than 85 percent, contractor shall return the difference; MLR greater than 95 percent, DHCS shall make additional payments to the contractor; and MLR between 85 percent and 95 percent, no MLR adjustment will be made to/from the contractor. The data is to be reported for two periods: 18 months (January 1, 2014, through June 30, 2015) and 12 months (July 1, 2015, through June 30, 2016). Our response is due March 9. CalOptima has reserved an appropriate level in anticipation of potential recoupment from the state.

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California Children's Services (CCS)/Whole-Child Model (WCM)
CalOptima has begun the yearlong process of transitioning the CCS program from a Medi-Cal carve-out administered by the Orange County Health Care Agency to the fully integrated WCM, overseen by CalOptima. This affects more than 13,000 Orange County children, all of whom have significant medical conditions. Transparency in this effort is a priority, and CalOptima has already held meetings with health network leaders and the general stakeholder community. In fact, our January meeting featuring Jacey Cooper, DHCS assistant deputy director, drew more than 100 attendees. Further, six family-focused forums are planned for this month to engage parents with children in the CCS program. In the spring, CalOptima staff will ask your Board to consider actions necessary to effectuate this change, including CalOptima's proposed approach of using our existing delivery system to provide CCS services. To guide our efforts, we are launching a WCM Family Advisory Committee, and individuals can apply until February 28 using the forms here. Overall, CalOptima is committed to a smooth transition that provides children with CCS conditions continued access to familiar providers essential to their care.

Health Homes Program
The Centers for Medicare & Medicaid Services recently approved California's proposal to create health homes to improve care for Medi-Cal beneficiaries with chronic health conditions. DHCS' Health Homes Program will begin the first phase of implementation in July 2018, and Orange County is expected to participate beginning January 1, 2019. The Orange County Health Care Agency is leading this effort, and CalOptima will be a participating entity.

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Financial Summary

December 2017

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- December 2017 MTD:
  - Overall enrollment was 791,476 member months
    - Actual lower than budget by 11,880 or 1.5%
      - Medi-Cal: unfavorable variance of 11,548 members
        - TANF unfavorable variance of 12,853 members
        - SPD unfavorable variance of 2,550 members
        - Medi-Cal Expansion (MCE) favorable variance of 3,653 members
        - LTC favorable variance of 202 members
      - OneCare Connect: unfavorable variance of 335 members
    - 6,531 or 0.8% increase from prior month
      - Medi-Cal: increase of 6,566 from November
      - OneCare Connect: decrease of 31 from November
      - OneCare: decrease of 6 from November
      - PACE: increase of 2 from November

FY 2017-18: Consolidated Enrollment

- December 2017 YTD:
  - Overall enrollment was 4,738,924 member months
    - Actual lower than budget by 76,296 or 1.6%
      - Medi-Cal: unfavorable variance of 74,994 members or 1.6%
        - TANF unfavorable variance of 73,891 members
        - SPD unfavorable variance of 15,898 members
        - MCE favorable variance of 13,778 members
        - LTC favorable variance of 1,017 members
      - OneCare Connect: unfavorable variance of 1,569 members or 1.7%
      - OneCare: favorable variance of 279 members or 3.5%
      - PACE: unfavorable variance of 12 member or 0.9%

FY 2017-18: Consolidated Revenues

- December 2017 MTD:
  - ➢ Actual higher than budget by $7.7 million or 2.8%
    - ▪ Medi-Cal: favorable to budget by $6.3 million or 2.6%
      - Unfavorable volume variance of $3.6 million
      - Favorable price variance of $9.9 million due to:
        - ➢ $6.2 million of FY18 Coordinated Care Initiative (CCI) revenues including In Home Supportive Services (IHSS) Dual and Non-Dual revenue
        - ➢ $2.0 million of FY18 revenue including LTC Revenue from Non-LTC members and Non-Medical Transportation
        - ➢ $1.7 million of FY18 Behavioral Health Treatment (BHT) revenue

FY 2017-18: Consolidated Revenues (cont.)

- December 2017 MTD:
  - OneCare Connect: favorable to budget by $1.2 million or 4.3%
    - Unfavorable volume variance of $0.6 million due to lower enrollment
    - Favorable price variance of $1.8 million due to FY18 rate increase
  - OneCare: favorable to budget by $0.1 million or 8.5%
    - Favorable volume variance of $9.3 thousand
    - Favorable price variance of $0.1 million due rate increase
  - PACE: favorable to budget by $86.7 thousand or 5.5%
    - Unfavorable volume variance of $39.5 thousand
    - Favorable price variance of $126.2 thousand

FY 2017-18: Consolidated Revenues (cont.)

- December 2017 YTD:
  - ➢ Actual higher than budget by $55.7 million or 3.4%
    - ▪ Medi-Cal: favorable to budget by $48.1 million or 3.3%
      - Unfavorable volume variance of $23.4 million
      - Favorable price variance of $71.5 million due to:
        - ➢ $30.3 million of FY18 CCI revenues including IHSS Dual and Non-Dual revenue
        - ➢ $9.4 million of FY18 BHT revenue
        - ➢ $6.0 million of FY17 LTC Revenue from Non-LTC members
        - ➢ $22.9 million of prior year revenue

FY 2017-18: Consolidated Revenues (cont.)

- December 2017 YTD:
  - OneCare Connect: favorable to budget by $8.5 million or 5.2%
    - Unfavorable volume variance of $2.8 million
    - Favorable price variance of $11.3 million due to 15% rate increase
  - OneCare: Unfavorable to budget by $1.5 million or 17.5%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $1.7 million
      - Due to Part D and Hierarchical Condition Category (HCC) reconciliation
  - PACE: favorable to budget by $0.6 million or 6.4%
    - Favorable price variance of $0.7 million due to Part D true-up

FY 2017-18: Consolidated Medical Expenses

- December 2017 MTD:
  - ➢ Actual lower than budget by $1.8 million or 0.7%
    - ▪ Medi-Cal: favorable variance of $3.0 million
      - Favorable volume variance of $3.5 million
      - Unfavorable price variance of $0.5 million
        - ➢ Prescription Drugs favorable variance of $4.5 million due to lower drug costs and $0.8 million in adjustments
        - ➢ Managed Long-Term Services and Support (MLTSS) unfavorable variance of $3.4 million due to $4.1 million for IHSS offset by favorable IBNR
        - ➢ Professional Claims unfavorable variance of $0.5 million
        - ➢ Facilities expenses favorable variance of $1.9 million
    - OneCare Connect: unfavorable variance of $0.4 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $0.9 million

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

- December 2017 YTD:
  - ➢ Actual higher than budget by $63.7 million or 4.0%
    - ▪ Medi-Cal: unfavorable variance of $61.5 million
      - Favorable volume variance of $22.4 million
      - Unfavorable price variance of $83.9 million
        - ➢ MLTSS expenses unfavorable variance of $38.5 million
        - ➢ Provider Capitation expenses unfavorable variance of $12.1 million
        - ➢ Professional Claims expenses unfavorable variance of $11.1 million
        - ➢ Facilities expenses unfavorable variance of $2.5 million
    - ▪ OneCare Connect: unfavorable variance of $5.1 million
      - Favorable volume variance of $2.6 million
      - Unfavorable price variance of $7.6 million
- Medical Loss Ratio (MLR):
  - ➢ December 2017 MTD: Actual: 93.5% Budget: 96.7%
  - ➢ December 2017 YTD: Actual: 95.9% Budget: 95.3%

FY 2017-18: Consolidated Administrative Expenses

- December 2017 MTD:
  - ➢ Actual lower than budget by $2.7 million or 21.3%
    - Purchased Services: favorable variance of $1.4 million due to lower claims processing fees
    - Other categories: favorable variance of $1.2 million

- December 2017 YTD:
  - ➢ Actual lower than budget by $16.0 million or 21.7%
    - Purchased Services: favorable variance of $6.8 million driven lower claims processing fees
    - Other categories: favorable variance of $9.1 million

- Administrative Loss Ratio (ALR):
  - ➢ December 2017 MTD: Actual: 3.5% Budget: 4.5%
  - ➢ December 2017 YTD: Actual: 3.4% Budget: 4.4%

FY 2017-18: Change in Net Assets

- December 2017 MTD:
  - $10.4 million surplus
  - $13.6 million favorable to budget
    - Higher than budgeted revenue of $7.7 million
    - Lower than budgeted medical expenses of $1.8 million
    - Lower than budgeted administrative expenses of $2.7 million
    - Higher than budgeted investment and other income of $1.5 million

- December 2017 YTD:
  - $23.0 million surplus
  - $17.0 million favorable to budget
    - Higher than budgeted revenue of $55.7 million
    - Higher than budgeted medical expenses of $63.7 million
    - Lower than budgeted administrative expenses of $16.0 million
    - Higher than budgeted investment and other income of $9.0 million

Enrollment Summary: December 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
62,897	63,796	(899)	(1.4%)	Aged	371,472	376,943	(5,471)	(1.5%)
617	618	(1)	(0.2%)	BCCTP	3,667	3,708	(41)	(1.1%)
47,146	48,796	(1,650)	(3.4%)	Disabled	282,234	292,620	(10,386)	(3.5%)
324,940	329,355	(4,415)	(1.3%)	TANF Child	1,954,853	1,978,286	(23,433)	(1.2%)
95,221	103,659	(8,438)	(8.1%)	TANF Adult	572,853	623,311	(50,458)	(8.1%)
3,470	3,268	202	6.2%	LTC	20,625	19,608	1,017	5.2%
240,355	236,702	3,653	1.5%	MCE	1,431,978	1,418,200	13,778	1.0%
774,646	**786,194**	**(11,548)**	**(1.5%)**	**Medi-Cal**	**4,637,682**	**4,712,676**	**(74,994)**	**(1.6%)**
15,223	**15,558**	**(335)**	**(2.2%)**	**OneCare Connect**	**91,570**	**93,139**	**(1,569)**	**(1.7%)**
235	**241**	**(6)**	**(2.5%)**	**PACE**	**1,359**	**1,371**	**(12)**	**(0.9%)**
1,372	**1,363**	**9**	**0.7%**	**OneCare**	**8,313**	**8,034**	**279**	**3.5%**
791,476	**803,356**	**(11,880)**	**(1.5%)**	**CalOptima Total**	**4,738,924**	**4,815,220**	**(76,296)**	**(1.6%)**

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Financial Highlights: December 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
791,476	803,356	(11,880)	(1.5%)	Member Months	4,738,924	4,815,220	(76,296)	(1.6%)
283,343,384	275,693,125	7,650,259	2.8%	Revenues	1,707,910,458	1,652,163,156	55,747,302	3.4%
264,819,397	266,593,714	1,774,317	0.7%	Medical Expenses	1,637,889,772	1,574,189,765	(63,700,007)	(4.0%)
9,868,144	12,531,002	2,662,858	21.3%	Administrative Expenses	57,484,517	73,447,504	15,962,987	21.7%
8,655,843	**(3,431,591)**	**12,087,434**	**352.2%**	**Operating Margin**	**12,536,170**	**4,525,887**	**8,010,282**	**177.0%**
1,753,228	231,157	1,522,071	658.5%	Non Operating Income (Loss)	10,463,272	1,429,716	9,033,556	631.8%
10,409,072	**(3,200,434)**	**13,609,506**	**425.2%**	**Change in Net Assets**	**22,999,442**	**5,955,603**	**17,043,839**	**286.2%**
93.5%	96.7%	3.2%		Medical Loss Ratio	95.9%	95.3%	(0.6%)	
3.5%	4.5%	1.1%		Administrative Loss Ratio	3.4%	4.4%	1.1%	
3.1%	(1.2%)	4.3%		Operating Margin Ratio	0.7%	0.3%	0.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima A Public Agency Better. Together.

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
8.6	(3.4)	12.0	Medi-Cal	6.0	4.9	1.1
0.9	0.1	0.8	OCC	5.3	0.7	4.6
(0.9)	(0.1)	(0.8)	OneCare	0.4	(0.8)	1.2
0.1	0.0	0.1	PACE	0.7	(0.3)	1.0
8.7	**(3.4)**	**12.1**	**Operating**	**12.5**	**4.5**	**8.0**
1.8	0.2	1.5	Inv./Rental Inc, MCO tax	10.5	1.4	9.0
1.8	**0.2**	**1.5**	**Non-Operating**	**10.5**	**1.4**	**9.0**
10.4	**(3.2)**	**13.6**	**TOTAL**	**23.0**	**6.0**	**17.0**

Consolidated Revenue & Expense: December 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	534,291	240,355	774,646	15,223	1,372	235	791,476
REVENUES							
Capitation Revenue	$ 149,550,891	$ 102,135,233	$ 251,686,124	$ 28,448,503	$ 1,534,959	$ 1,673,799	$ 283,343,384
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	149,550,891	102,135,233	251,686,124	28,448,503	1,534,959	1,673,799	283,343,384
MEDICAL EXPENSES							
Provider Capitation	36,303,674	50,858,648	87,162,322	11,235,554	447,657	-	98,845,532
Facilities	23,872,453	18,656,453	42,528,906	3,210,266	1,104,483	362,097	47,205,752
Ancillary	-	-	-	616,337	37,263	-	653,599
Skilled Nursing	-	-	-	-	37,274	-	37,274
Professional Claims	7,131,177	8,009,498	15,140,675	-	-	364,135	15,504,810
Prescription Drugs	17,569,103	15,156,897	32,726,000	4,664,471	366,475	115,465	37,872,411
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	52,418,742	2,507,446	54,926,188	5,128,691	-	-	60,054,879
Medical Management	1,433,200	707,697	2,140,898	656,180	244,767	524,928	3,566,773
Reinsurance & Other	514,736	306,787	821,524	149,243	6,556	101,045	1,078,367
Total Medical Expenses	139,243,086	96,203,426	235,446,512	25,660,741	2,244,474	1,467,669	264,819,397
Medical Loss Ratio	**93.1%**	**94.2%**	**93.5%**	**90.2%**	**146.2%**	**87.7%**	**93.5%**
GROSS MARGIN	**10,307,805**	**5,931,807**	**16,239,612**	**2,787,762**	**(709,515)**	**206,129**	**18,523,988**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,946,204	942,919	31,110	93,341	7,013,574
Professional fees			(12,396)	(41,108)	13,333	1,333	(38,837)
Purchased services			574,731	157,754	20,880	5,269	758,635
Printing and Postage			168,884	113,562	25,677	16,238	324,361
Depreciation and Amortization			363,827	-	-	2,168	365,995
Other expenses			1,065,091	10,826	0	8,730	1,084,647
Indirect cost allocation, Occupancy expense			(486,904)	746,957	93,065	6,652	359,770
Total Administrative Expenses			7,619,437	1,930,910	184,066	133,732	9,868,144
Admin Loss Ratio			**3.0%**	**6.8%**	**12.0%**	**8.0%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			8,620,175	856,852	(893,581)	72,398	8,655,843
INVESTMENT INCOME			-	-	-	-	1,741,395
NET RENTAL INCOME			-	-	-	-	10,623
NET GRANT INCOME			1,202	-	-	-	1,202
OTHER INCOME			9	-	-	-	9
CHANGE IN NET ASSETS			**$ 8,621,386**	**$ 856,852**	**$ (893,581)**	**$ 72,398**	**$ 10,409,072**
BUDGETED CHANGE IN ASSETS			(3,359,402)	84,693	(137,190)	(19,692)	(3,200,434)
VARIANCE TO BUDGET - FAV (UNFAV)			11,980,788	772,159	(756,391)	92,090	13,609,505

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Consolidated Revenue & Expense: December 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	3,205,704	1,431,978	4,637,682	91,570	8,313	1,359	4,738,924
REVENUES							
Capitation Revenue	$ 896,748,544	$ 621,909,649	$ 1,518,658,193	$ 172,821,540	6,827,621	$ 9,603,105	$ 1,707,910,458
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	896,748,544	621,909,649	1,518,658,193	172,821,540	6,827,621	9,603,105	1,707,910,458
MEDICAL EXPENSES							
Provider Capitation	232,526,166	301,737,891	534,264,057	66,959,450	(82,082)	-	601,141,425
Facilities	150,939,577	114,544,752	265,484,329	16,958,305	2,493,220	1,669,718	286,605,573
Ancillary	-	-	-	3,671,043	259,231	-	3,930,274
Skilled Nursing	-	-	-	-	137,375	-	137,375
Professional Claims	45,190,403	50,012,643	95,203,046	-	-	2,092,469	97,295,516
Prescription Drugs	106,067,583	107,258,732	213,326,314	30,570,998	2,694,595	686,870	247,278,778
MLTSS Facility Payments	322,052,369	15,282,844	337,335,213	31,955,995	-	17,511	369,308,718
Medical Management	11,564,805	4,414,375	15,979,180	5,936,423	313,962	3,144,440	25,374,005
Reinsurance & Other	3,366,596	1,789,334	5,155,930	1,025,648	44,691	591,838	6,818,107
Total Medical Expenses	871,707,498	595,040,572	1,466,748,070	157,077,862	5,860,993	8,202,847	1,637,889,772
Medical Loss Ratio	**97.2%**	**95.7%**	**96.6%**	**90.9%**	**85.8%**	**85.4%**	**95.9%**
GROSS MARGIN	**25,041,045**	**26,869,078**	**51,910,123**	**15,743,679**	**966,628**	**1,400,257**	**70,020,687**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			32,115,166	4,614,066	147,105	445,788	37,322,124
Professional fees			910,290	101,538	92,349	16,672	1,120,849
Purchased services			4,142,909	913,306	116,036	30,413	5,202,664
Printing and Postage			1,631,480	461,190	56,758	21,416	2,170,844
Depreciation and Amortization			2,473,970	-	-	12,936	2,486,906
Other expenses			6,748,013	241,462	(32)	89,710	7,079,154
Indirect cost allocation, Occupancy expense			(2,173,902)	4,070,948	160,830	44,100	2,101,976
Total Administrative Expenses			45,847,925	10,402,510	573,046	661,036	57,484,517
Admin Loss Ratio			**3.0%**	**6.0%**	**8.4%**	**6.9%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			6,062,198	5,341,169	393,582	739,222	12,536,170
INVESTMENT INCOME			-	-	-	-	10,480,161
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(71,525)	-	-	-	(71,525)
OTHER INCOME			533	-	-	-	533
CHANGE IN NET ASSETS			**$ 5,991,207**	**$ 5,341,169**	**$ 393,582**	**$ 739,222**	**$ 22,999,442**
BUDGETED CHANGE IN ASSETS			4,922,764	717,666	(835,563)	(278,979)	5,955,603
VARIANCE TO BUDGET - FAV (UNFAV)			1,068,443	4,623,503	1,229,145	1,018,201	17,043,839

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Balance Sheet:
As of December 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$481,885,979	Accounts payable	$13,807,781
	Investments	833,329,387	Medical claims liability	964,364,976
	Capitation receivable	383,482,587	Accrued payroll liabilities	9,341,768
	Receivables - Other	17,374,740	Deferred revenue	167,061,116
	Prepaid Expenses	4,986,816	Deferred lease obligations	158,970
			Capitation and withholds	382,720,721
	Total Current Assets	**1,721,059,509**	**Total Current Liabilities**	**1,537,455,331**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,618,397
	Building/Leasehold improvements	6,228,243		
	505 City Parkway West	49,433,337	Net Pension Liabilities	16,365,263
		89,700,629	Long Term Liabilities	100,000
	Less: accumulated depreciation	(38,197,224)		
	Capital assets, net	**51,503,404**	**TOTAL LIABILITIES**	**1,583,538,991**
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	30,352,767	Tangible net equity (TNE)	88,937,308
	Long term investments	506,544,015	Funds in excess of TNE	647,520,526
	Total Board-designated Assets	536,896,783		
	Total Other Assets	**537,196,783**	**Net Assets**	**736,457,834**
	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		**2,321,336,835**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,321,336,835**

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Board Designated Reserve and TNE Analysis
As of December 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,736,596				
	Tier 1 - Logan Circle	146,622,040				
	Tier 1 - Wells Capital	146,295,076				
Board-designated Reserve		439,653,712	301,731,893	469,161,551	137,921,819	(29,507,839)
TNE Requirement	Tier 2 - Logan Circle	97,243,070	88,937,308	88,937,308	8,305,763	8,305,763
	Consolidated:	536,896,783	390,669,201	558,098,859	146,227,581	(21,202,076)
	Current reserve level	*1.92*	*1.40*	*2.00*		

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HN Enrollment Summary - Medi-Cal

Health Network Name	JANUARY 2018	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	149,112	19.2%	22.5%
Monarch Family HealthCare (HMO16)	83,339	10.8%	12.6%
CalOptima Community Network (CN)	74,080	9.6%	11.2%
Arta Western Health Network (SRG66)	67,658	8.7%	10.2%
Family Choice Health Network (PHC21)	47,082	6.1%	7.1%
Kaiser Permanente (HMO04)	45,537	5.9%	6.9%
Alta Med Health Services (SRG69)	45,290	5.8%	6.8%
Prospect Medical Group (HMO17)	34,887	4.5%	5.3%
United Care Medical Network (SRG67)	33,528	4.3%	5.1%
Noble Mid-Orange County (SRG64)	27,945	3.6%	4.2%
Talbert Medical Group (SRG65)	23,555	3.0%	3.6%
AMVI Care Health Network (PHC58)	23,550	3.0%	3.6%
Heritage - Regal Medical Group (HMO15)	4,960	0.6%	0.7%
OC Advantage (PHC35)	1,896	0.2%	0.3%
Total Health Network Capitated Enrollment	**662,420**	**85.5%**	**100.0%**
CalOptima Direct (all others)	112,284	14.5%	
Total Medi-Cal Enrollment	**774,704**	**100.0%**	

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HN Enrollment Summary – OneCare Connect

Health Network Name	JANUARY 2018	Percentage
Monarch HealthCare (HMO16DB)	4,852	32.2%
Propect Medical Group (HMO17DB)	2,770	18.4%
Family Choice Medical Group (SRG81DB)	1,845	12.3%
CalOptima Community Network (CN)	1,701	11.3%
Talbert Medical Group (SRG52DB)	1,108	7.4%
Arta Western Health Network(SRG66DB)	531	3.5%
Alta-Med (SRG69DB)	522	3.5%
United Care Medical Group (SRG67DB)	498	3.3%
AMVI Care Health Network (PHC58DB)	455	3.0%
Noble Mid Orange County (SRG64DB)	449	3.0%
Heritage - Regal Medical Group (HMO15)	213	1.4%
OC Advantage (PHC35DB)	105	0.7%
Total OneCare Connect Enrollment	**15,049**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	JANUARY 2018	Percentage
Monarch HealthCare (PMG53DE)	671	50.5%
AMVI/Prospect Medical Group (PMG27DE)	312	23.5%
Talbert Medical Group (PMG52DE)	99	7.4%
Family Choice Medical Group (PMG21DE)	86	6.5%
Arta Western Health Network (PMG66DE)	67	5.0%
Alta-Med (PMG69DE)	50	3.8%
United Care Medical Group (PMG67DE)	31	2.3%
Noble Mid Orange County (PMG64DE)	14	1.1%
Total OneCare Enrollment	**1,330**	**100.0%**

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Member Health Needs Assessment

Provider Advisory Committee
February 8, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

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A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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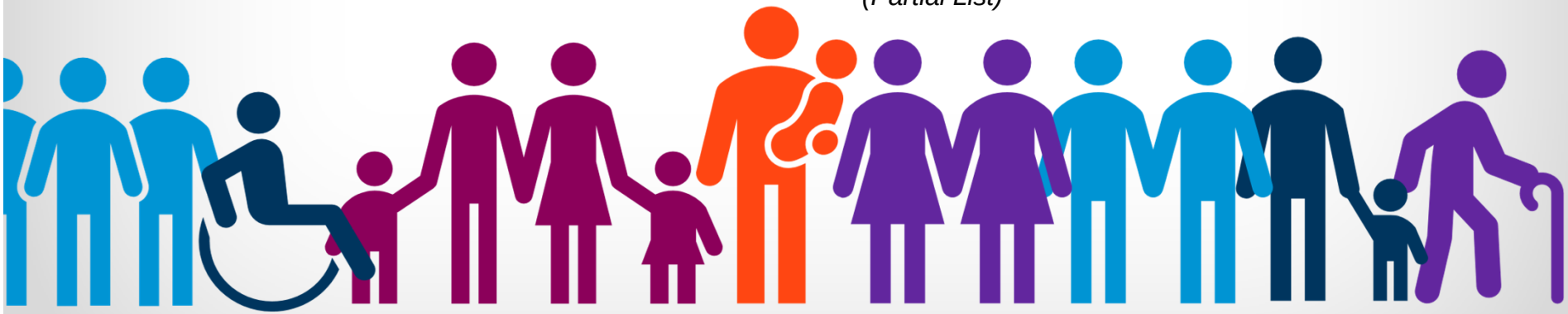
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

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More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

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More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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More Engaging: Members

Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

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Offering Deeper Insight

- ➔ Barriers to Care
- ➔ Lack of Awareness About Benefits and Resources
- ➔ Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - ➢Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - ➢Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

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Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year
- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

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Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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Eight RFPs

Description	Funding Amount
Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	$5 million
Expand Mental Health and Socialization Services for Older Adults	$500,000
Expand Access to Mental Health/ Developmental Services for Children 0–5 Years	$1 million
Nutrition Education and Fitness Programs for Children and Their Families	$1 million
Medi-Cal Benefits Education and Outreach	$500,000
Expanded Access to Primary Care and Programs Addressing Social Determinants of Health	$4 million
Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services	$1.4 million
Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services	$1 million
Total	**$14.4 million**

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

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CalOptima's Mission

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

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EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

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CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

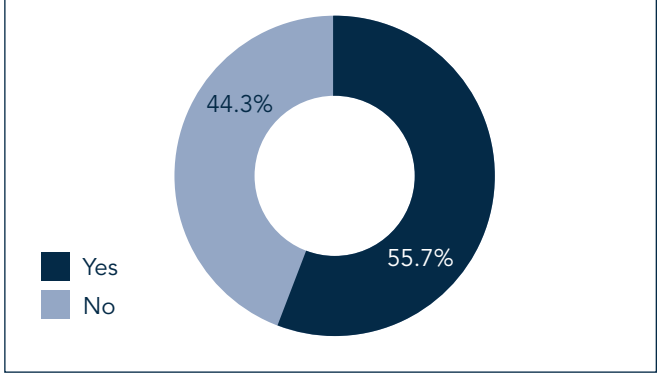
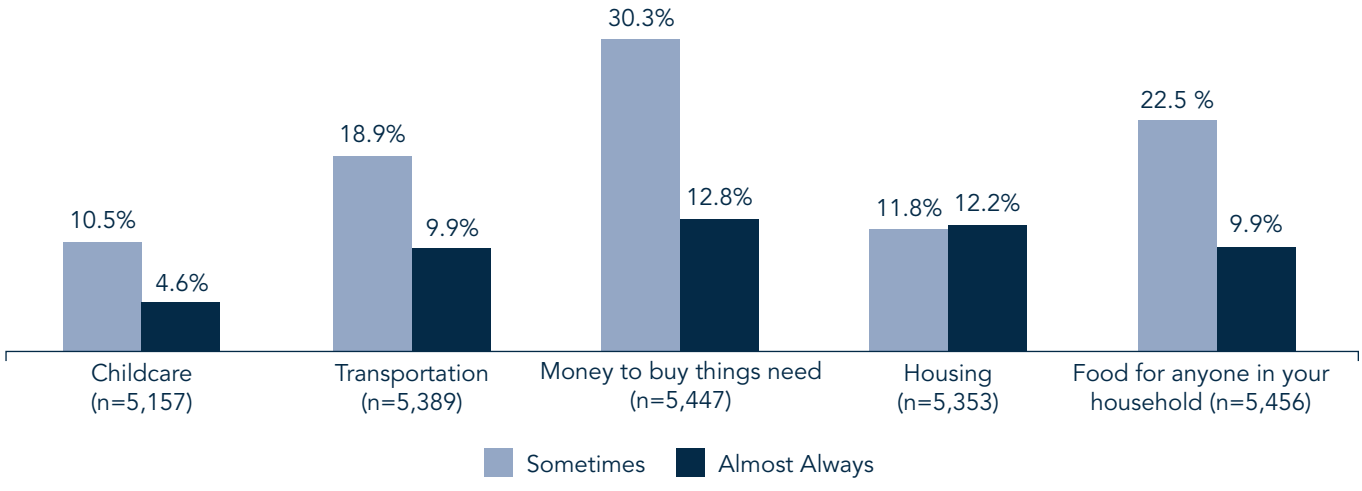
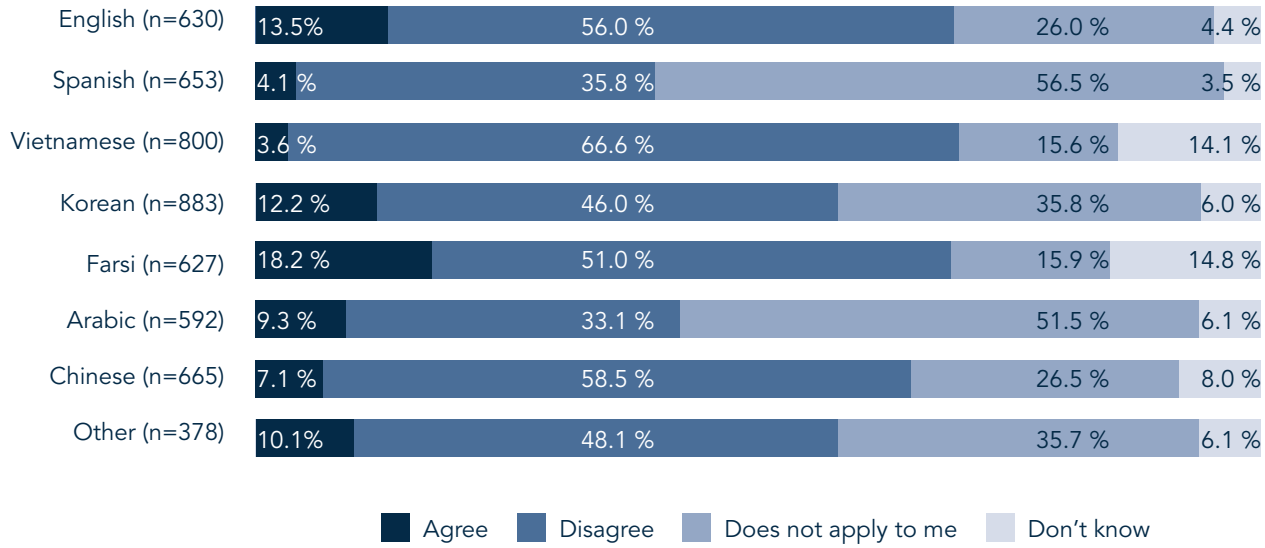


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

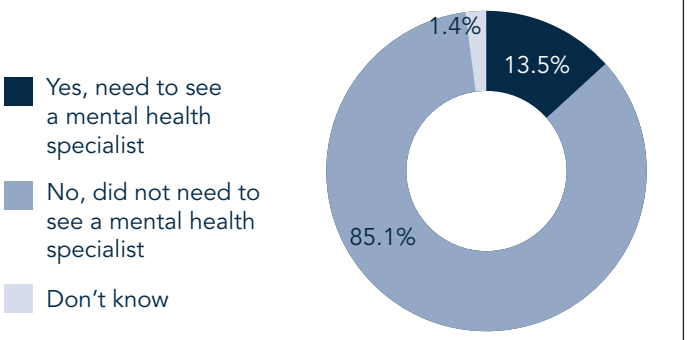
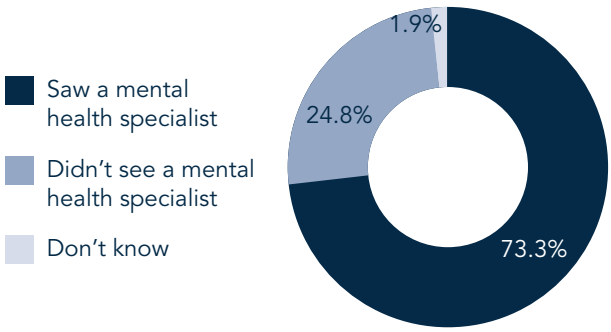
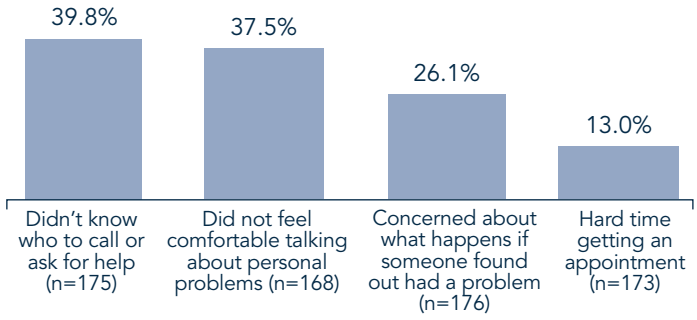


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

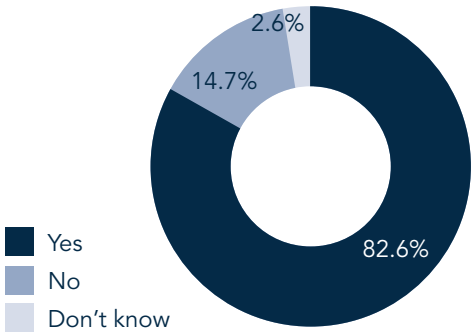
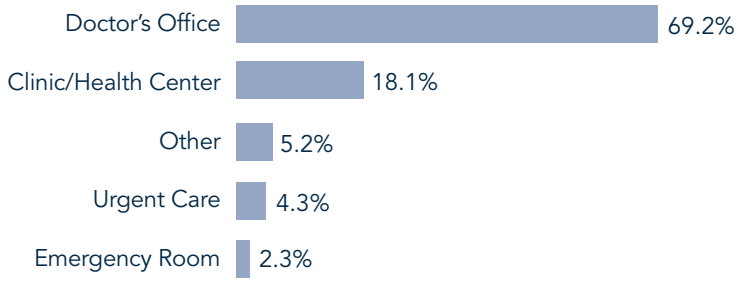


Exhibit 9: Where respondents go to see their doctor (n=5,743)

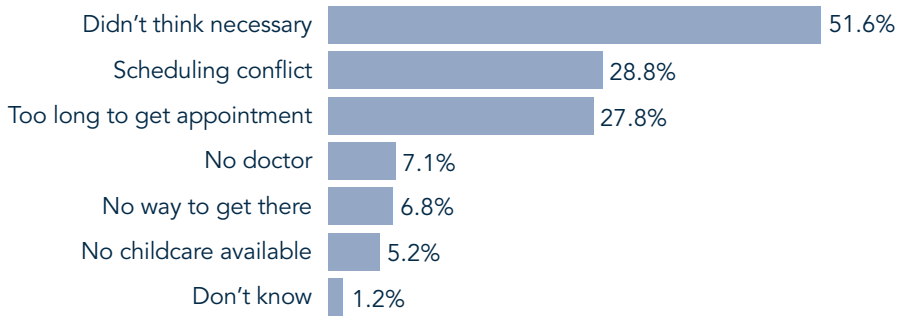


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

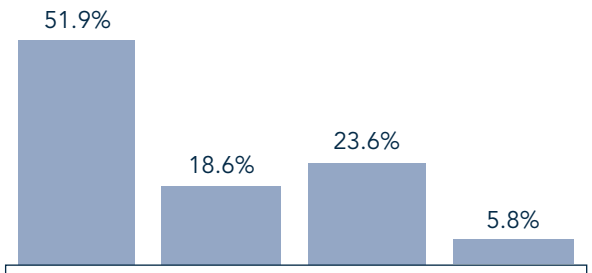
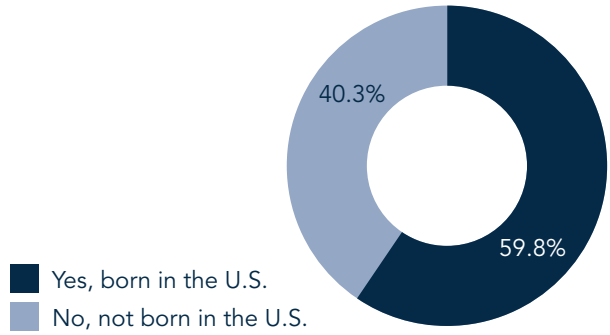


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

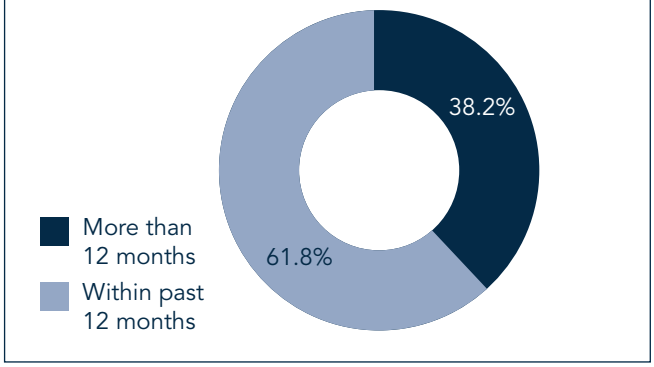
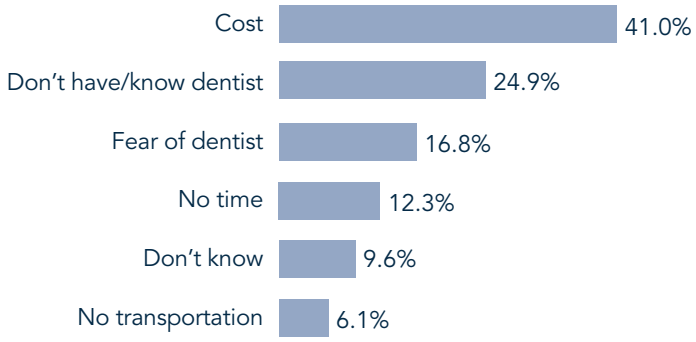


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

2017 Year-End Federal Activity: Medicaid Impacts

There was a flurry of congressional activity in the last several months of 2017 that will affect the Medicaid program and CalOptima. The two most impactful legislative actions, H.R. 1 (the Tax Cuts and Jobs Act) and H.R. 1370 (Continuing Resolution of FFY 2017-18 funding), are summarized below.

I. H.R. 1: Tax Cuts and Jobs Act

H.R. 1, officially referred to as the Tax Cuts and Jobs Act, was signed into law by President Trump on December 22, 2017, and amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. While most of its income tax-related provisions are effective January 1, 2018, the elimination of the penalty associated with the Affordable Care Act's individual mandate is effective December 31, 2018.[1]

Background and Basic Provisions
The bill's most significant change is a reduction of the corporate income tax rate from 35 to 21 percent, effective January 1, 2018. Congress' Joint Committee on Taxation estimates that this will increase the federal deficit by almost $1.4 trillion over ten years, which accounts for the majority of H.R. 1's economic impact.[2]

Both the federal deficit increase and the elimination of the individual mandate penalty in 2019 will have health care impacts, with most estimates predicting overall health care coverage losses ranging from five million fewer insured (S&P Global) to 13 million fewer insured (CBO) over ten years.[3]

Medicaid/CalOptima Impact
The CBO anticipates that one million fewer people will enroll in Medicaid in 2019 due to the elimination of the individual mandate penalty. By 2027, this number is expected to rise to five million.

In addition, the less immediately quantifiable, but potentially more harmful impact to the Medicaid program could be related to the Tax Bill's increase of the federal deficit. In short, the greater the federal deficit, the greater the pressure on legislators to reduce federal spending. Some lawmakers have already signaled their intention to explore the possibility of reducing Medicare and Medicaid appropriations – 15 and 11 percent of the federal budget respectively[4] – as part of future efforts to reduce the federal deficit.[5] It is likely that efforts to reduce federal Medicaid and Medicare spending will proceed through the 2019 federal budget process as budget reconciliation legislation.

At this point, it is difficult to quantify the Tax Bill's potential impacts on CalOptima. It is possible that Orange County residents potentially eligible for Medi-Cal may choose not to enroll without the impetus of the individual mandate's penalty. California could potentially enact its own state-based mandate, similar to that of Massachusetts, among other measures, to encourage the young and healthy to obtain health care. There has been discussion in the state legislature's health committees and among health care industry leaders regarding this topic. Staff will continue to track and analyze these discussions as well as federal budget negotiations for potential impact to CalOptima.

Vote
Overall, the vote on H.R. 1 in the House was 224 yeas to 201 nays. The Orange County House delegation was divided on the tax bill. Reps. Mimi Walters and Ed Royce voted for H.R. 1 and Reps. Darrell Issa, Dana Rohrabacher, Alan Lowenthal, Lou Correa and Linda Sanchez all voted against the bill. In the U.S. Senate, the vote was split down party lines, with 51 Republican yeas and 48 Democratic nays. Both Sens. Dianne Feinstein and Kamala Harris voted against the bill.

II. The 2017-18 Federal Budget: Current Spending Levels Continued

H.R. 1370, a continuing resolution (CR) signed into law by the President on December 22, 2017, funds the federal government at current levels through January 19, 2018. The CR also allocates $2.85 billion to the Children's Health Insurance Program (CHIP), which will fund the program for the first half of the federal fiscal year, until March 31, 2018.

However, the stopgap spending bill does not address several outstanding health policy and fiscal issues, such as funding for CHIP beyond March, cost sharing reductions associated with both federal and state individual marketplace exchanges[6] and the status of Deferred Action for Childhood Arrivals (DACA) recipients. These issues may be dealt with by January 19, when Congress will again be faced with the need to pass spending legislation or face the potential of a federal government shutdown.

CalOptima Impact
Without further Congressional action on CHIP and DACA, CalOptima could potentially experience reductions in membership and funding. More than 112,000 CalOptima

members access care through CHIP. These are children whose family income is between 101 and 266 percent of the federal poverty level. Without a longer-term reauthorization of CHIP funding, some states, including California, will have to bear the burden of a federal fiscal shortfall.

Additionally, CalOptima has approximately 13,000 members who are DACA recipients. These individuals qualify for full scope Medi-Cal through CalOptima by virtue of their DACA status. In the absence of further congressional action, some of these members may lose Medi-Cal eligibility as they lose their DACA status and revert to undocumented status. DACA adults (over the age of 19) will lose CalOptima membership should they revert to undocumented status. DACA children (under 19) who revert to undocumented status will maintain their CalOptima membership due to SB 75, state legislation that extended full scope Medi-Cal coverage to undocumented children. Staff will continue to track DACA and CHIP related developments and assess Orange County impacts as Congress nears the January 19 deadline to addresses federal spending issues.

Vote
The vote on H.R. 1370 in the House was 231 yeas to 188 nays. Reps. Mimi Walters, Ed Royce, Darrell Issa, and Dana Rohrabacher voted for the bill and Reps. Alan Lowenthal, Lou Correa and Linda Sanchez all voted against. The Senate voted 66 to 32 in favor of the CR, with both Sens. Feinstein and Harris voting against the bill.

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 (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

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Endnotes

[1] HR 1, Part VIII, Sec. 11081(b)

[2] $1.389 trillion increase in the federal deficit - Joint Committee on Taxation and Penn Wharton Budget Model

[3] S&P Global, "U.S. Tax Reform: Repeal Of The Health Insurance Mandate Will Save Less Than Expected, And Will Not Support The Current Insurance Market," Nov. 17, 2017

[4] See Center on Budget and Policy Priorities, https://www.cbpp.org/research/federal-budget/policy-basics-where-do-our-federal-tax-dollars-go; and Kaiser Family Foundation, "Facts on Medicare Spending and Financing," available at: https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

[5] "Ryan says Republicans to target welfare, Medicare, Medicaid spending in 2018" Washington Post, December 6, 2017, available at: https://www.washingtonpost.com/news/wonk/wp/2017/12/01/gop-eyes-post-tax-cut-changes-to-welfare-medicare-and-social-security/?utm_term=.9887a098c84f

[6] "Senator Susan Collins' (ME) has postponed until 2018 her efforts to pass CSR and reinsurance (payments to insurers to help pay claims for high-cost enrollees) bills. Her support for the tax bill was predicated upon support for these two bills, see http://www.modernhealthcare.com/article/20171220/NEWS/171229990

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Governor's 2018-19 Budget Proposal Analysis and CalOptima Impacts

January 2018

Overview

On January 10, 2018, the Governor released his 2018-19 state budget proposal. The total budget proposal is $190.3 billion, with General Fund spending at $131.7 billion, which is more than a seven percent increase compared to current year spending. This increase is due to the Governor's expectation that the state's fiscal outlook will remain stable, because of California's continuing economic expansion. As such, the state's health care programs are not expected to face cuts in the coming fiscal year. In fact, the Medi-Cal program is expected to see an 11 percent increase in funding, as detailed below. However, though the state-level fiscal and policy outlook for Medi-Cal may be positive, changes to the Medicaid program at the federal-level have the potential to change this position drastically. These and other major issues that are pertinent to the agency are addressed below.

On a related note, in both his press conference and the budget proposal summary, the Governor mentioned that the budget does not account for the potential impact of H.R. 1, the Tax Cuts and Jobs Act, which was signed into law by President Trump on December 22, 2017. The May revision of the budget proposal will assess any impact related to H.R. 1's revision of corporate and individual income tax rates.[1]

Medi-Cal Budget

FY 2018–19 Proposed Medi-Cal Budget[2]

General Fund	$21.6 billion (11 percent increase from 2017 Budget Act)
Federal Funds	$67.1 billion (includes $21.3 billion for MCE)[3]
Other	$12.8 billion (includes $850 million in Prop. 56 funds)[4]
Total	**$101.5 billion**

The increase in General Fund dollars allocated to Medi-Cal funding is based on an estimated enrollment of 13.5 million members.[5]

Of note, the federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as "Medi-Cal classic", there is a 50/50 match. For the Medi-Cal expansion (MCE) population, there is an enhanced federal match (94/6 for calendar year 2018 and 93/7 for calendar year 2019). For the Children's Health Insurance Program (CHIP) population, there is currently an 88/12 match. The "other" portion of the Medi-Cal budget, by and large, accounts for state funds that are drawn from the special funds pool, which includes, for instance, tobacco tax dollars designated for Medi-Cal. A large portion of the revenue raised by Proposition 56's expansion of the tobacco tax, approved by California voters in November 2016, is designated for augmenting the state's Medi-Cal budget through supplemental payments for physicians and dentists, among other health care treatment expenditures. Accordingly, the budget estimates that Medi-Cal will receive $850 million for such expenditures in FY 2018-19.

CHIP Reauthorization

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. The program was known as the Healthy Families program in California before its integration into Medi-Cal in 2013. California's federal match for CHIP funding is currently 88/12, which includes a 23 percent increase authorized under the terms of the Affordable Care Act (ACA). Federal funding for the program expired on September 30, 2017. On December 22, 2017, Congress authorized additional, temporary funding for CHIP that will fund the program through March 31, 2018 as part of H.R. 1370 – a continuing resolution to temporarily fund the federal government until January 19, 2018.

The budget proposal's calculations and estimates were finalized before H.R. 1370 passed, so it assumes a lower federal match for CHIP beginning January 1, 2018 (65/35), than was included in the continuing resolution (88/12). The May revise will include savings of approximately $150 million General Fund to account for this.[7] Due to a maintenance of effort requirement associated with the

ACA, the state will be obligated to continue covering most of the 1.2 million children that currently access care through CHIP – individuals whose family income is between 101 and 266 percent of the federal poverty level – regardless of the status of funding reauthorization.[8] However, absent further Congressional action, California will have to bear the burden of any federal funding shortfall. This could potentially add billions of dollars of pressure to the state's Medi-Cal budget.[9] CalOptima has approximately 112,000 children enrolled in Medi-Cal through CHIP funding.

Additional Proposition 56 Medi-Cal Funding

California voters approved Proposition 56 in November 2016, which increased state taxes on tobacco products. A large portion of the revenue raised by Proposition 56 is designated for supplementing the state's Medi-Cal budget. The 2018-19 Budget allocates $850 million of this revenue to Medi-Cal health care treatment expenditures. The Governor is proposing that $650 million of this be allocated to supplemental payments to physicians and dentists providing services to Medi-Cal beneficiaries in high need areas or providers in high need specialties, which represents a $232 million increase compared to 2017-18 levels. However, the efficacy of the supplemental payments in expanding access to Medi-Cal services – by encouraging additional provider participation or increasing the number of Medi-Cal beneficiaries served – will be reevaluated by the Administration in the spring.[10] After this evaluation, these payment methodologies may be modified or revised accordingly. CalOptima will be working with the Department of Health Care Services (DHCS) to ensure that eligible Orange County Medi-Cal providers have the opportunity to participate in the supplemental payments program.

Changes to 340B Drug Reimbursements in Medi-Cal

Section 340B of the Public Health Service Act program requires drug manufacturers to provide pharmaceuticals to covered entities, such as Disproportionate Share Hospitals (DSHs) and Federally Qualified Health Centers (FQHCs), at or below 340B ceiling prices, which are generally much lower than retail. In 2014, the Office of Inspector General for the federal Department of Health and Human Services found significant issues with the program, including duplicative discounts and inconsistencies in identifying eligible prescriptions. Since then, states have been scrutinizing the implementation of 340B. In California, current law allows covered entities to purchase pharmaceuticals for Medi-Cal patients at 340B prices. In turn, this requires DHCS to closely audit the program to remain in compliance with federal requirements. In its overview of the budget proposal, the Department notes that it has found inconsistencies in the billing practices of 340B entities. According to DHCS, this has increased state expenditures, created higher pharmacy costs for Medi-Cal managed care plans and created substantial administrative burden on the state related to ensuring 340B entities are in compliance with existing law and regulation.

As such, the Department is proposing trailer bill language that would prohibit the use of 340B drugs in Medi-Cal starting July 1, 2019. Given that many clinics and hospitals rely on the 340B program to provide low cost drugs to their patients, this portion of the budget is likely to be thoroughly debated in the coming months. Based on initial staff analysis, some of CalOptima's contracted providers may experience negative financial impacts if the 340B program is completely eliminated. Details of the proposal will become clearer as DHCS releases the text of its proposed trailer bill language. Staff will continue to monitor and analyze the potential impacts to the agency and our contracted providers.

Medi-Cal Expansion

The budget proposal assumes continued funding of the Medicaid expansion (MCE) population at current levels.[11] CalOptima currently has 238,000 MCE members. However, based on information that CalOptima has received from DHCS, we believe that the capitation rates plans are paid for the MCE population will continue to decrease in the coming year, based on the acuity level of these beneficiaries. Also, it is important to note that while the budget proposal assumes continuation of current federal law, it acknowledges the potential for significant change at the federal level impacting Medicaid and Medicare.

Next Steps

The Governor's January budget proposal is just the first step in the state's budget process. The Legislature will now begin holding budget hearings in an effort to build consensus. The Governor will then release a revision to the January budget proposal in May, and the Legislature will have until June 15 to submit a final state budget for the Governor's approval. CalOptima will continue to closely follow these ongoing budget discussions and provide updates regarding any issues that have a significant impact on the Agency.

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. 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 (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

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

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Endnotes

[1] *see* CalOptima Policy Paper, "2017 Year-End Federal Activity: Medicaid Impacts."
[2] Department of Health Care Services, "2018-19 Governor's Budget Highlights."
[3] Governor's Budget Summary 2018-19, p. 59
[4] Ibid, p. 57
[5] Ibid, p. 59
[6] "Annual Enrollment Reports," Centers for Medicare and Medicaid Services, https://www.medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.
[7] Governor's Budget Summary 2018-19, p. 55
[8] The Affordable Care Act established the CHIP maintenance of effort (MOE) requirement when it passed in 2010, which requires states to maintain CHIP income eligibility levels through FFY 19 and established the enhanced CHIP match. See CalOptima Policy Paper, "Children's Health Insurance Program (CHIP) in Orange County."
[9] California's CHIP budget for FY 2017-18 is 3.2 billion.
[10] Local Health Plans of California, 2018-19 Budget Analysis
[11] Governor's Budget Summary 2018-19, p. 53

“Tele Health in Pediatric Cardiology.”

Speaker: Anjan Batra, M.D.

(Professor, Division Chief and Vice Chair of Pediatrics)

Faculty Disclosure - *The speaker has no financial relationships to disclose.*

Financial Disclosure – *No commercial support was received for this activity.*

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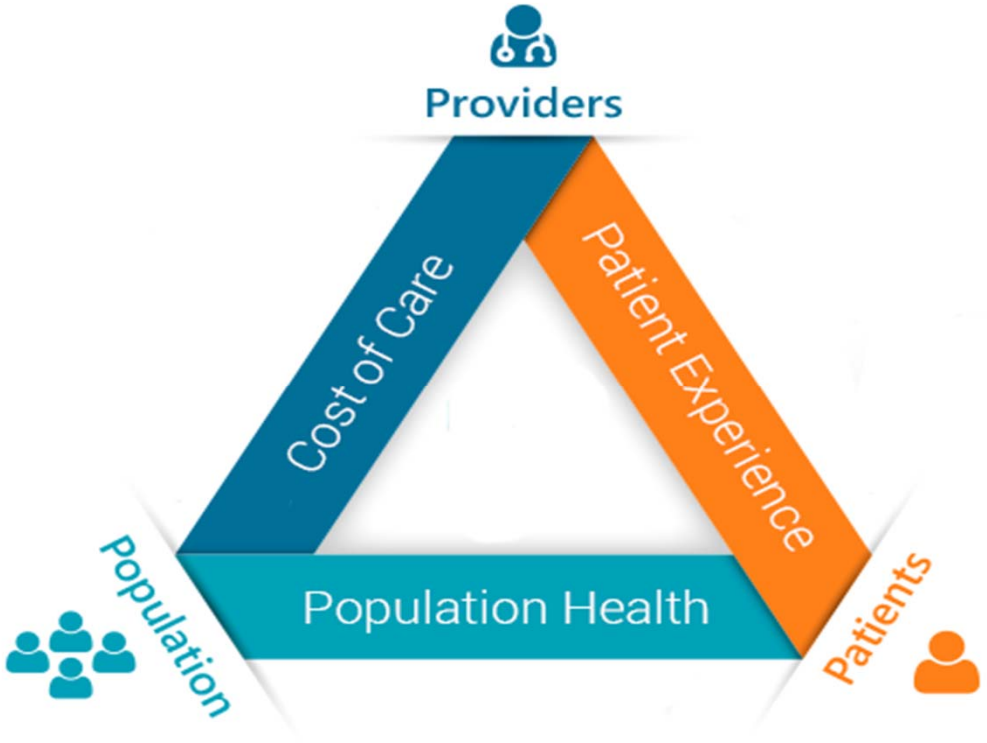
TheTriple Aim?



A Telemedicine Based App To Allow Pediatricians to Better Care for Your Child

Pediatrician

Telemedicine App

Cardiologist

Enhancing Communication between Providers to Improve Care and Reduce Costs

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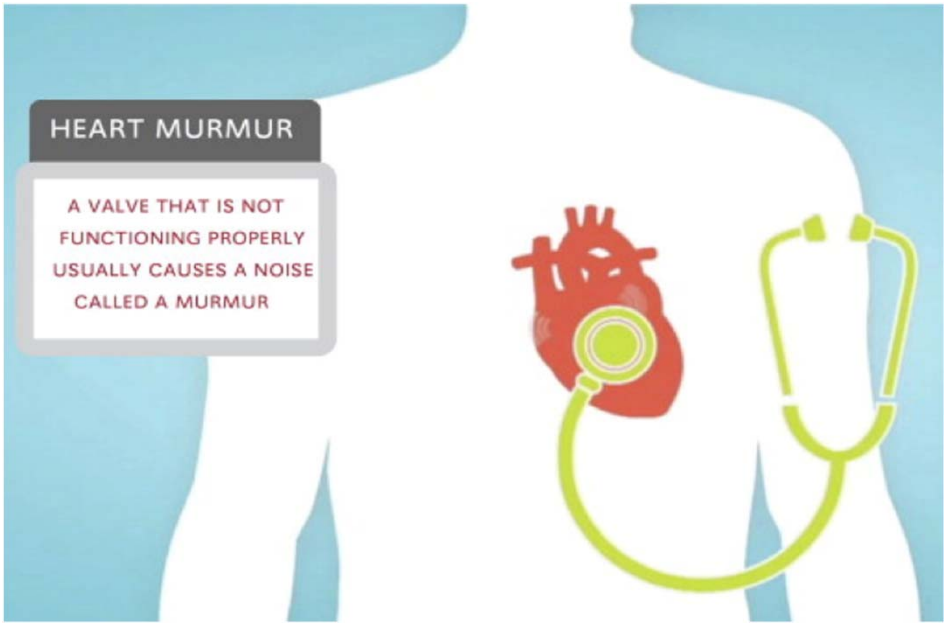
Population Health + Cost

- 80% of pediatricians report difficulty with heart murmurs and arrhythmias



- Shortage of Cardiologists
  - 31,000 general pediatricians vs 1500 pediatric cardiologists in the US
- Average cost = $1,000/visit

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Patient Experience

- 96% of parents/guardians missed work for doctors' appointments

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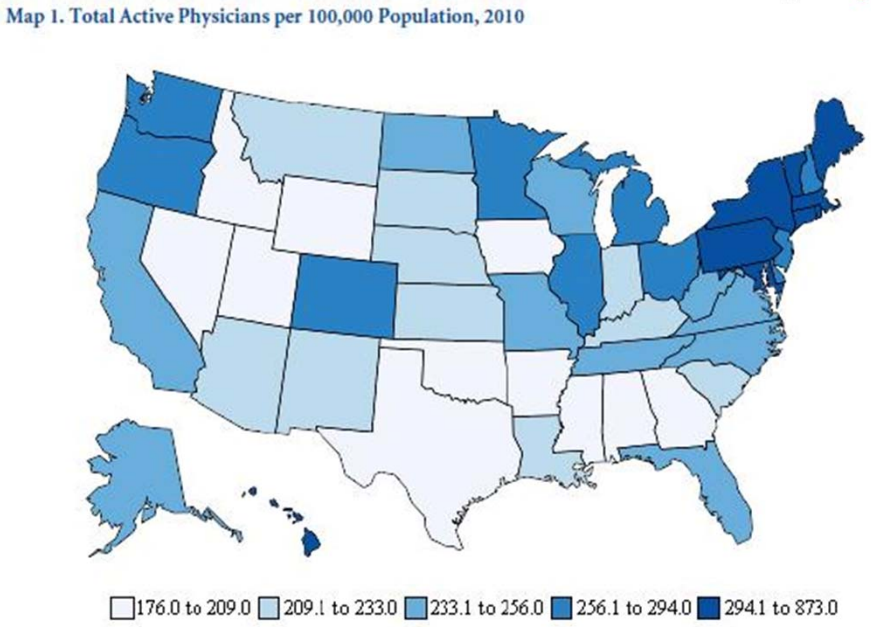
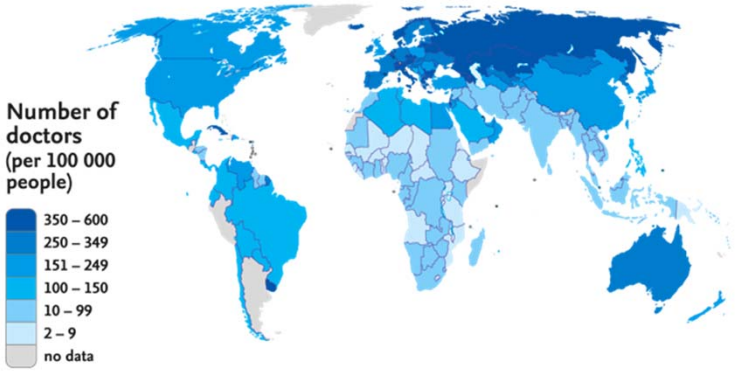
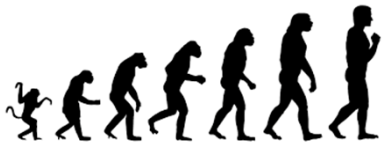
Unequal Distribution

- 20% of the US population lives in rural underserved areas.





The Solution



eConsult
Access to information. Access to care.

- Pilot Program: Telemedicine App Platform

Cardiac Consult

- Telemedicine App Platform with ECG and Stethoscope

•60% reduction in wait times

• 46% reduction in face-to-face visits

•Rapid responses to clinical questions in under 3 days

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The Telemedicine Market

	Video Chat	Pediatric Care	Medical Records	Heart Rhythm	Heart Sounds
Amwell	X	X			
Avera	X	X	X		
MD Live	X				
Health Link Now	X	X			
Doctor on Demand	X	X			
United Concierge Medicine	X	X			
Cardiac Consult	X	X	X	X	X

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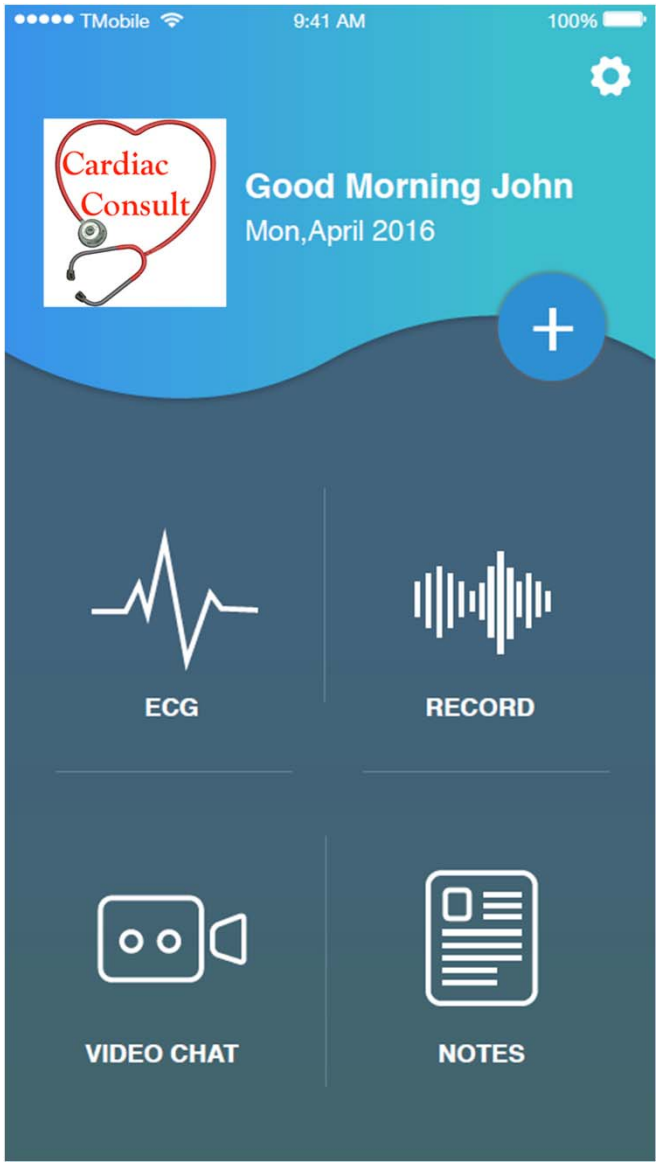
CARDIAC CONSULT

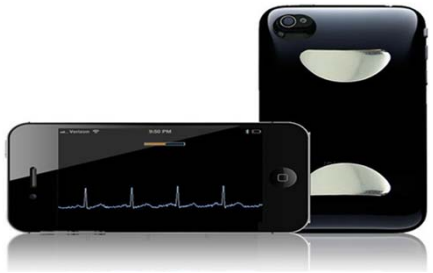
✓ IRB Approved

✓ HIPPA Compliant

✓ FDA Approved



Stethoscope



Heart Rhythm

Ultrasound Imaging

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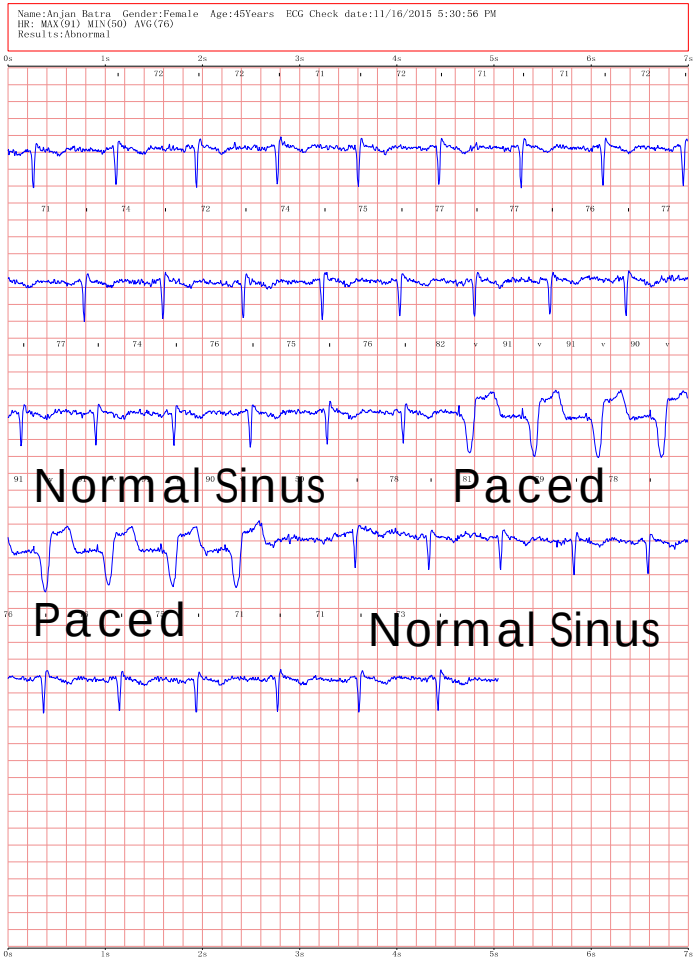
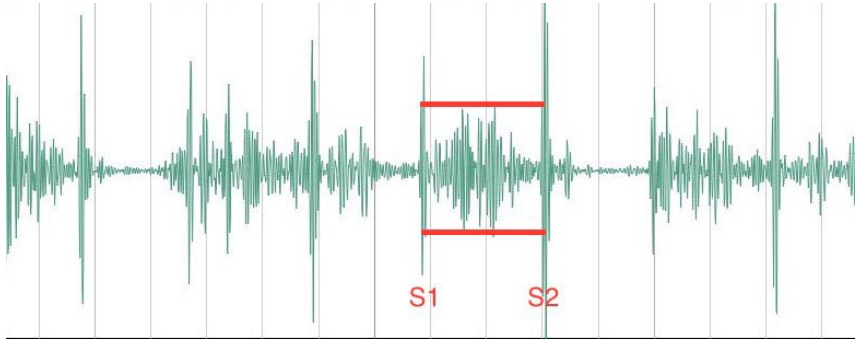
Demos



Thinklabs One Stethoscope

(VSD)



INCENTIVES

Pediatrician

- Increased scope of service

Insurance Companies

- Reduced additional tests (ultrasounds etc)

Cardiologist

- Bill for teleconsult

Patient

- Improved productivity, time and satisfaction

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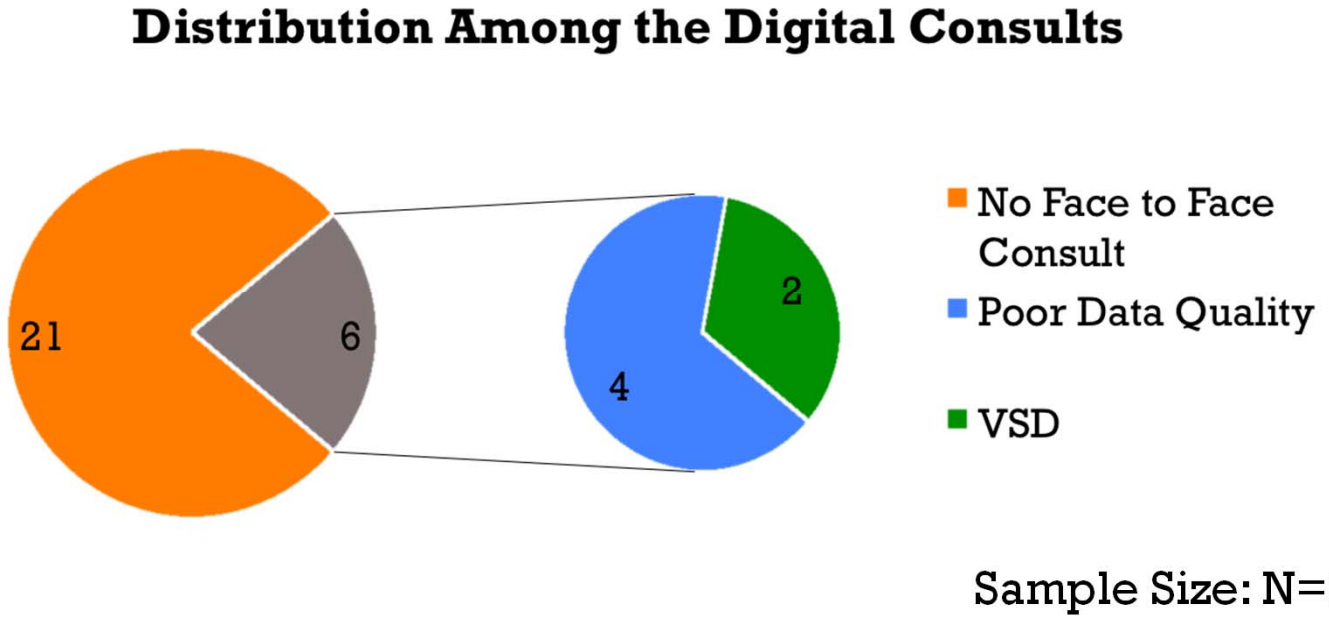
A FEASIBILITY STUDY



Sample Size: N=27

Awarded the 2016 COCIT (Council on Clinical Information Technology) Best Poster Award at the AAP National Conference Exhibition

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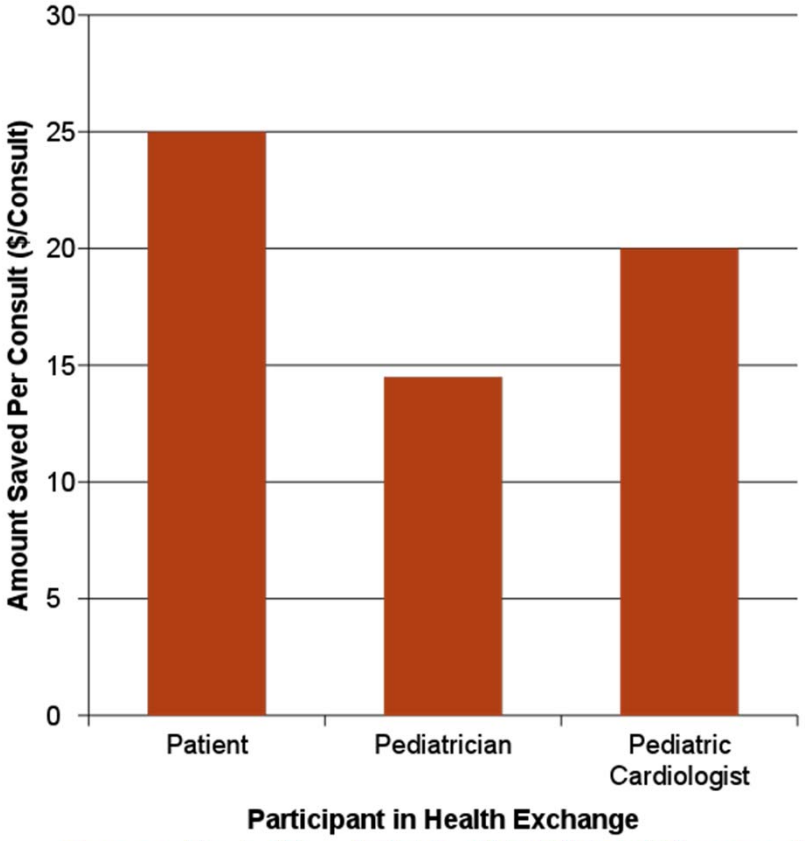
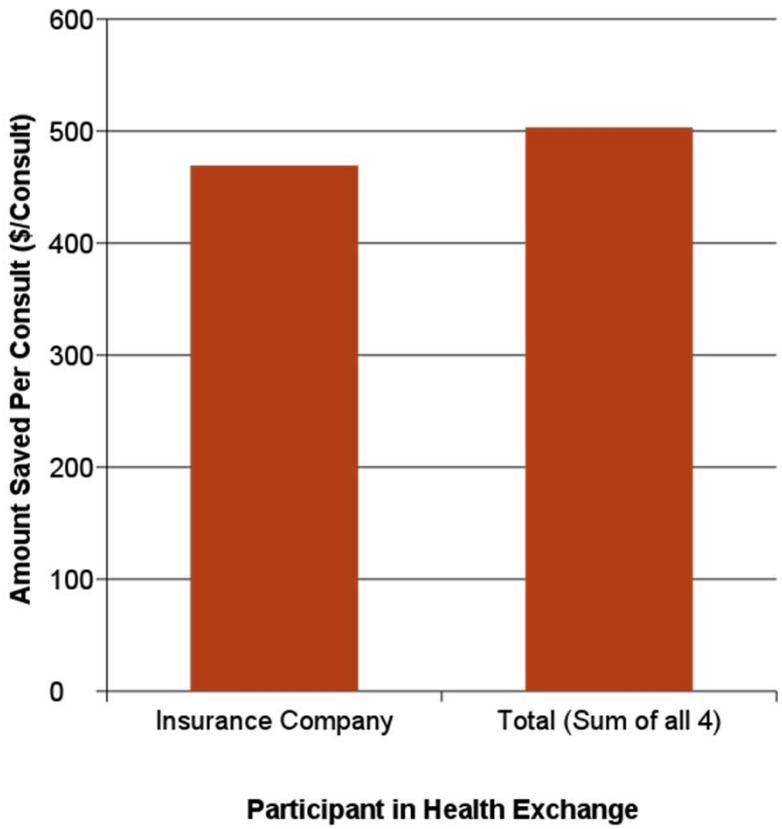
A FEASIBILITY STUDY





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A FEASIBILITY STUDY

Survey	Average Response (#/10)
How comfortable do you feel differentiating between a benign and pathologic murmur?	**6.4**
How convenient is a cardiology consult for your patients in a timely manner?	**9.2**
How willing are you to use any new technology?	**7.8**
How would you rate the Thinklabs stethoscope?	**6.3**
How would you rate the ECG check hardware?	**6.8**

Awarded the 2016 COCIT (Council on Clinical Information Technology) Best Poster Award at the AAP National Conference Exhibition

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Problem	Our Solution
Medical Record Documentation	Files automatically upload to electronic medical record
FDA Device Approval	Our devices are FDA approved
Malpractice	Already covered under insurance plans

Outreach

- Physicians can interpret the data from across the world.

El Salvador 2016

OUR TEAM

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