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

THURSDAY, DECEMBER 13, 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 September 13, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC)
B. Approve Minutes of the October 11, 2018 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC)

IV. PUBLIC COMMENT
At this time, members of the public may address the Committee on general topics. Public Comment on posted item(s) will follow staff presentation of the item(s) to the Committee. If you wish to speak on an item contained in the agenda, please complete a Public Comment Request Form(s) identifying the item(s) and submit the form to the assistant to the Provider Advisory Committee. When addressing the Committee, it is requested that you state your name for the record. Please address the Committee as a whole through the Chair. Comments to individual Committee members or staff are not permitted. Speakers will be limited to three (3) minutes.

V. 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. Whole-Child Model Update
B. Intergovernmental Transfer Funds (IGT) 8 and 9 Update
C. Children's Hospital of Orange County (CHOC) Pediatric and Adolescent Mental Health Initiative
D. Provider Advisory Committee Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

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MINUTES

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

September 13, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, September 13, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:04 a.m. Vice Chair Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Brian Lee, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Suzanne Richards, MBA, FACHE
Members Absent:	Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Greg Hamblin, Chief Financial Officer, Len Rosignoli, Chief Information Officer, Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Sesha Mudunuri, Executive Director, Operations and Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the August 9, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Flood, seconded and carried, the Committee approved the minutes of the August 9, 2018 meeting. (Motion carried 12-0-0; Members Pimentel and Sweidan absent)***

PUBLIC COMMENTS

1. Desiree Plunbett, Med X Medical Billing – Oral re: Authorizations, eligibility, contracting, billing and reimbursement for the Whole-Child Model.
2. Phiet Phung, M.D., Medical Director and Gastroenterologist, HealthCare Partners (Arta Western and Talbert Medical Group); Lourdes Alberto, Network Management and MSO on

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behalf of Prospect Medical Group and AMVI Care Health Network - Oral re: Agenda Item V.A., Consider CalOptima Delivery System Overview and Related Recommendations.

3. Phiet Phung, M.D., Medical Director and Gastroenterologist, HealthCare Partners (Arta Western and Talbert Medical Group); Lourdes Alberto, Network Management and MSO on behalf of Prospect Medical Group and AMVI Care Health Network; Alan Tran, M.D. Tim Lai, M.D., and Dillon Tran, M.D., Family Choice Health Network – Oral; and Nami Si Dong, M.D., Pediatrician – Written re: Agenda Item V.B., Consider Recommendations Related to Changes to the Member Auto-Assignment Limits for the CalOptima Community Network

REPORTS

Consider CalOptima Delivery System Overview and Related Recommendations
Greg Hamblin, Chief Financial Officer, reviewed the presentation on the CalOptima Delivery System as requested by the CalOptima Board of Directors at their September 6, 2018 meeting. PAC requested clarification on the Board directive from Staff and asked questions to ensure that they understood the directive.

Consider Recommendations Related to Changes to the Member Auto-Assignment Limits for the CalOptima Community Network
Mr. Hamblin reviewed the presentation on changes to the member auto-assignment limits for the CalOptima Community Network. The Board has directed the PAC and the Member Advisory Committee (MAC) to review and bring back recommendations.

The PAC recommended rescheduling the joint meeting with the Member Advisory Committee (MAC) and the OneCare Connect Advisory Committee (OCC MAC) from November to October 11, 2018 at 8:00 a.m. Each advisory committee will then formulate their individual committee recommendations before the November 1, 2018 Board meeting. Additionally, the PAC recommended convening a joint ad hoc meeting with the MAC and OCC MAC to formulate an agenda for the October 11, 2018 joint meeting.

Action: ***On motion of Member Jensen, seconded and carried, the Committee approved convening a Joint Meeting with the MAC and the OCC MAC for further discussion on the proposed changes to CalOptima's delivery system and the proposed changes to member auto-assignment limits for the CalOptima Community Network. (Motion carried 12-0-0; Members Pimentel and Sweidan absent)***

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that CalOptima is preparing to submit information to the Department of Health Care Services (DHCS) on the Readiness Assessment for the Whole-Child Model scheduled to begin on January 1, 2019. The DHCS will send the 90-day notice to members affected by the transfer to CalOptima, and CalOptima will send the 60 and the 30-day notices w to the affected members. She also noted that CalOptima continues to conduct

community outreach to the members and providers to ensure authorization issues are addressed in advance.

Chief Medical Officer Update
Emily Fonda, M.D., Medical Director, provided an update on the Whole-Child Model (WCM), and noted that the first meeting of the WCM Clinical Advisory Committee is scheduled on September 25, 2018. The Committee consists of five pediatric specialists, one primary care physician, and an Orange County Medical Director.

INFORMATION ITEMS

Health Homes Program Update
Candice Gomez, Executive Director, Program Implementation provided a brief update on the Health Homes Program that is scheduled to begin on July 1, 2019.

PAC Member Updates
Chair Nishimoto reminded PAC members that the deadline to complete annual compliance training is November 9, 2018.

ADJOURNMENT
There being no further business before the Committee, Chair Nishimoto adjourned the meeting at 10:00 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Project Manager/Staff to the PAC

Approved: December 13, 2018

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MINUTES

SPECIAL JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE AND PROVIDER ADVISORY COMMITTEE

October 11, 2018

A Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC) was held on Thursday, October 11, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Molnar called the meeting to order at 8:10 a.m., and Chair Corzo led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler; Diana Cruz-Toro; Connie Gonzalez; Donna Grubaugh; Jaime Muñoz; Ilia Rolon; Jacqueline Ruddy; Sr. Mary Therese Sweeney; Christine Tolbert; Mallory Vega

Members Absent: Sandy Finestone; Elizabeth Anderson

OneCare Connect Member Advisory Committee

Members Present: Gio Corzo, Chair; Patty Mouton, Vice-Chair; Josefina Diaz; Keiko Gamez, (8:30 AM); Sara Lee; George Crits (non-voting); Erin Ulibarri (non-voting)

Members Absent: Ted Chigaros; Christine Chow, Sandy Finestone; Richard Santana; Jyothi Atluri (non-voting)

OCC MAC did not achieve quorum.

Provider Advisory Committee

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Suzanne Richards, MBA, FACHE; Jacob Sweidan, M.D.

Members Absent: Dr. Lee

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Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Sesha Mudunuri, Executive Director, Operations, Albert Cardenas, Director, OneCare Connect Customer Service, Le Nguyen, Associate Director, Customer Service, Cheryl Simmons, Staff to the Advisory Committees, Eva Garcia, Customer Service and Kathi Porcho, Provider Relations

PUBLIC COMMENTS

1. Kenneth McFarland, Chief Executive Officer, Fountain Valley Regional Hospital and Medical Center; Lourdes Alberto, Sr. Vice President, Network Management, Prospect Medical Group; Javier Sanchez, Chief IPA Administrator, CHOC Health Alliance; Oral and written re: Agenda Item IV.A., Consider Recommendations Related to CalOptima Delivery System Overview and Related Recommendations.

2. Lowell Gordon, M.D., Medical Director, Family Choice Health Network; Kenneth McFarland, Chief Executive Officer, Fountain Valley Regional Hospital and Medical Center; Lourdes Alberto, Sr. Vice President, Network Management, Prospect Medical Group; Javier Sanchez, Chief IPA Administrator, CHOC Health Alliance – Oral; Nikan Khatibi, M.D., Physician and CalOptima Board Member; Chris Celio, M.D., Family Medicine Physician; Smita Tandon, M.D. Pediatric Physician; Brennan Cassidy M.D., Family Medicine Physician; Samara Cardenas, M.D.; Pediatric Physician; Ray Garcia Lora, M.D., Pediatric Physician; Annu Sharma, M.D., Pediatric Physician; James Striebig, M.D., Internal Medicine Physician; Bob Sankaram, M.D., Nephrologist; Quynh Kieu, M.D., Pediatric Physician; Raman Chopra, M.D., Pediatric Physician - Written re: Agenda Item IV.B., Consider Recommendations Related to Changes to the Member Auto-Assignment Limits for the CalOptima Community Network.

REPORTS

Consider Recommendations related to CalOptima's Delivery System

At the request of the CalOptima Board of Directors at its September 6, 2018 meeting, the MAC and the PAC met to discuss the Board directive to make a recommendation on the proposal to consider issuing a Request for Proposal for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider delivery system. Members of the Committees raised concerns about the lack of a clear estimate of costs associated with retaining a consultant, costs associated with undertaking a Request for Proposal (RFP), as well as the impact on available staff resources with the implementation of the Whole-Child Model program beginning on January 1, 2019, and the Health Homes Program beginning on July 1, 2019. The Committees also discussed CalOptima's fifth consecutive annual award as the top rated Medi-Cal plan in the State—results achieved utilizing the current delivery system model.

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After substantial discussion of the matter, the MAC and the PAC took the following actions.

Action: ***On motion of Member Jensen, seconded and carried, the PAC unanimously opposed the Delivery System proposal as there is no clear estimate of what the costs would be, and concerns exist about the drain on CalOptima's staff resources. PAC is not clear what the goal is with regard to this item. (Motion carried 12-0-0; Member Lee absent.)***

Action: ***On motion of Member Rolon, seconded and carried, MAC unanimously opposes the Delivery System proposal on the basis that there is no clear understanding of the intent of this delivery system review. MAC also has concerns about the drain on staff resources and the cost for such a project. (Motion carried 11-0-0; Members Anderson, Finestone, absent.)***

Consider Recommendations Related to Changes to the Member Auto-Assignment Limits for the CalOptima Community Network (CCN)

The September 6, 2018 Board directive also included a request for the advisory committees to review of proposed changes to CCN auto-assignment. As part of the discussion and to bring context and clarity to the Committees, PAC Member Jensen read portions of the original CalOptima Ordinance that was again reiterated by the then seated Board in 2010 in its response to whether or not CalOptima should participate in the State's health care exchange under the Affordable Care Act.

The MAC and the PAC engaged in further discussion and concluded that leaving the cap in place would have no impact on Member choice in their selection of a provider. The Committees also noted that Members have the option to choose a health network and make changes of networks and primary care providers on a monthly basis if they so desire.

Action: ***On motion of Member Jensen, seconded and carried, the PAC unanimously opposed the lifting of the CCN auto-assignment cap as it has no impact on Member choice and noted that Members continue to be free to choose CCN if they so desire. (Motion carried 12-0-0; Member Lee absent.)***

Action: ***On motion of Member Mouton, seconded and carried, MAC members unanimously rejected the request to increase the 10% Cap on Auto-Assignment for the CCN noting that it does not affect Members as they have the option of selecting their own network and primary care provider every 30 days. (Motion carried 11-0-0; Members Anderson and Finestone absent.)***

ADJOURNMENT

Chair Molnar announced that the next Special Joint Meeting would be held on November 8, 2018 at 2:30 p.m.

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There being no further business before the Committees, Chair Molnar adjourned the meeting at 9:54 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Project Manager/Staff to the PAC

Approved: November 8, 2018 – Member Advisory Committee

Approved: December 13, 2018 – Provider Advisory Committee

Attachments: Written Public Comments

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Fountain Valley Regional
HOSPITAL & MEDICAL CENTER
Your hospital, your well-being

October 11, 2018

HAND DELIVERED

Ms. Sally Monar, Chair
CalOptima Member Advisory Committee
John H. Nishimoto, O.D., MBA, F.A.A.O., Chair
CalOptima Provider Advisory Committee
505 City Parkway West
Orange, CA 92868

RE: COMMENTS ON RECOMMENDATIONS RELATED TO (A) CALOPTIMA'S DELIVERY SYSTEM AND (B) CHANGES TO THE MEMBER AUTO-ASSIGNMENT LIMITS FOR THE CALOPTIMA COMMUNITY CARE NETWORK (CCN)

Dear Ms. Monar and Dr. Nishimoto:

On behalf of Fountain Valley Regional Hospital and Medical Center, I am pleased to submit these comments for consideration by your advisory committees, the CalOptima Board of Directors and senior leadership on the above-referenced recommendations, which are scheduled to return to the Board for additional discussion and/or action at its November 2018 meeting.

Fountain Valley Regional has been a major provider partner and strong supporter of CalOptima since the program's inception, and our hospital's role has steadily increased to become CalOptima's largest private hospital traditional and safety net partner. We take this obligation and commitment seriously and we maintain an outstanding record of providing efficient, quality healthcare services along with our physician and other partners (via the original Physician-Hospital Consortia model).

It is from this perspective we offer these comments on the pending recommendations.

RECOMMENDATIONS RELATED TO CALOPTIMA'S DELIVERY SYSTEM

We strongly support periodic, systemic, and transparent comprehensive reviews of CalOptima's delivery system and which should be conducted at regular intervals.

This is critical if one believes, as we do, that state-federal Medicaid funding will almost surely decline in future years. We must remember at all times that California's Medi-Cal program remains chronically underfunded; and, any and all efforts should be made to maximize the amount of resources that can be invested – or reinvested via savings – into efficient, higher quality care for CalOptima members.

Orange County has a de facto private safety net; and, CalOptima should continue to work closely with those who have shown the most commitment and dedication in preserving it for all residents, rich and poor alike. Therefore, we need to be planning together to best position CalOptima's delivery system to ensure that CalOptima – as a steward of taxpayer funds – is utilizing every dollar as effectively and efficiently as possible by investing in and incentivizing only in healthcare delivery models that ensure such a result.

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Today, many such proven models involve provider partners assuming "risk" and it is in CalOptima's best long term interest to continue to delegate such risk to those community partners willing and able to do so in order to maximize the use of these public funds.

Delivery of healthcare today also includes many dominant, well proven operational and patient management principles including utilization review and management and a wide array of patient and quality-related outcome metrics. Government also continues to tilt incentives heavily toward aligning all providers of care (i.e., value based care and other payment models), which should remain a prerequisite for CalOptima's future healthcare delivery design, including continued assignment of risk.

In our opinion, CalOptima should ensure that its members benefit from – and are directed for services in – such efficient, higher quality systems of care, which we deploy and utilize for all patients, whether commercial, government-sponsored (Medicare and Medi-Cal) or uninsured.

We are therefore pleased that all forms of network delivery of care within CalOptima will be included in the review. We also strongly encourage the addition of any and all relevant metrics not already collected for CCN and other networks, such as, hospital length of stay, readmission rates, member complaints and provider grievance and appeals.

Only a true "apples-to-apples" comparison will identify for CalOptima, its Board and community stakeholder partners, the most efficient and higher quality delivery models; and, serve as a basis for future planning and reviews. In short, the "dashboard" comparing delivery networks or models of care should be as comprehensive and meaningful as possible. Importantly, risk adjustment for complexity of illness should be a key factor in any analysis.

Finally, we hope this review will identify – and recommend solutions for – gaps in our delivery system for CalOptima's members and how we might invest and organize solutions. The results should enable CalOptima to appropriately leverage, utilize, incentivize and support its partners that are proven to provide higher quality and efficient care (as well as recognize those who remain committed to doing so for the long term). Such an approach will also enable CalOptima to reinvest savings from more efficient, quality delivery of care toward the long-term stability of its overall provider network.

RECOMMENDATIONS RELATED CHANGES TO THE MEMBER AUTO-ASSIGNMENT LIMITS FOR THE CALOPTIMA COMMUNITY CARE NETWORK

We believe any proposal to modify CalOptima's existing auto-assignment methodology and policy, including lifting the current cap on the Community Care Network (CCN), should not be considered in a vacuum (and as a single, separate question); and, instead should be more thoroughly analyzed and reviewed as part of the overall delivery system analysis that will be conducted.

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CCN was originally established to manage patients already in the CalOptima Direct network, patients that were "unmanaged". The overall delivery system review will better enable the Board to determine whether continuing to grow CCN is the most efficient use of public funds because we will be able to compare CCN's overall performance on critical metrics with other networks of care.

For example, data was recently presented to the CalOptima Board detailing ongoing member disenrollment rates from various networks following their initial auto assignment to another network. Some may argue this should justify permitting CCN to grow even larger. We believe additional analysis would be illustrative about the "disenrollment dynamic". For example, is there is a predominate subset of CCN physicians that members are realigning to? Are those physicians also in other networks? Following disenrollment by patients, is the utilization of services impacted? Are such members more or less likely to have more complex or chronic illnesses or conditions?

We also believe that, in undertaking a more comprehensive review of the auto-assignment policy, CalOptima could take the opportunity to modernize the policy and align such changes with the results of the larger, delivery system analysis. Ultimately, two primary drivers of auto assignment of members should be assigning patients to CalOptima's most efficient partners; and, to target assignments to those providers who consistently have taken on a larger share of traditional and safety net obligations with and for CalOptima members.

In closing, be assured that Fountain Valley Regional, and our parent company (Tenet Healthcare), remain committed to CalOptima and Orange County's de facto private safety net. We look forward to additional opportunities to provide care delivery insights and comments to your advisory committees, Milliman and others in the coming weeks and months. Thank you for considering our views on these important and germane issues.

Sincerely,

Kenneth McFarland
Chief Executive Officer

cc: Members, CalOptima Board of Directors
Members, CalOptima Member and Provider Advisory Committees
Michael Schrader, CEO, CalOptima
Other Interested Parties

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To: Members, Board of Directors, CalOptima
Members, Provider Advisory Committee
Members, Member Advisory Committee

October 4, 2018

Dear Respected Leaders,

We are writing this letter to express our **SUPPORT in lifting the cap** of the auto-assignment for the CalOptima Community Network (CCN).

CalOptima has two primary models of contracting with providers: delegation to health networks and direct contracts with individual physicians. CalOptima launched its direct contracting model, known as CalOptima Community Network (CCN), in 2014, with the goal of ensuring an adequate provider network to serve CalOptima's membership, which was growing significantly at that time due to the state's expansion of Medi-Cal after passage of the federal Affordable Care Act (ACA). New members who join CalOptima have the option of choosing their health network and their primary care physician (PCP). If the new member does not select a health network, then CalOptima "auto assigns" the member into one of CalOptima's networks.

Since the establishment of CCN, there has been a policy of stopping auto assignment of members into CCN once its total enrollment reaches 10% of CalOptima's total membership while the health networks could continue receiving patient assignments. **We find this to be totally unfair and are recommending this unmerited cap to be lifted!!**

CalOptima's mission states that it wants to expand access to members and ensure maximal physician participation. If that's the case, you need to keep the CCN going and give physicians and members the choice to participate. Here are few reasons why the CCN cap needs to be removed to ensure member access and physician participation.

- CCN providers takes the worst-case scenario patients (complex patients) including patients with hemophilia, end stage renal disease, cystic fibrosis, muscle dystrophy, organ transplant, and more - the health networks do not. Why then do we need to limit access for these members?
- CCN has the greatest number of unique physicians – meaning they do not participate in the other health networks, only CCN. This is proof that without the CCN, members would not have access and it would restrict access for members.
- The more options CalOptima provides for physicians to participate in the CalOptima delivery system, the more physicians who would be willing to participate - which means expanded access.
- Even among the general CalOptima membership, staff data suggests that the CCN takes more complex members.
- For any provider to remain engaged, they must have access to members, which means the CCN needs to be continually refreshed.

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- CCN is on a fee for service plan, but is in a managed care model with the very same principles as a health network. This includes members being assigned to PCPs, utilization review processes, case management, and care coordination.
- Based on staff analysis, removing the 10% auto assignment cap CCN would have minimal impact on medical and administrative expenses. Additionally, only 7.8% of members would be auto assigned to CCN, while 92.2% of members would continue to be auto assigned to delegated health contracts.

On a more personal note, I am disappointed at the conversations I am hearing about providers. Often times we talk about CalOptima providers and think about the Health Networks (HN), but we forget about the THOUSANDS of physicians who are providing care daily on the front lines. Despite the fact the auto assignment is off, CalOptima members are still voluntarily opting to enroll in the CCN which is a sign of their desire to remain in the CCN and relationship they have with their physician provider, not health network.

I hope you will join the thousands of physicians providing exceptional access and care to the most vulnerable members of our community, by voting in **SUPPORT of lifting the cap** of the auto-assignment for the CalOptima Community Network (CCN).

Thank you for the privilege of your time.

Sincerely,

Nikan Khatibi
Physician
Board Member, CalOptima – representing the community physician seat

Chris Cellio MD
Family Medicine Physician

Annu Sharma MD
Pediatric Physician

Smita Tandon MD
Pediatric Physician

James Streibig MD
Internal Medicine Physician

Brennan Cassidy MD
Family Medicine Physician

Bob Sankaram MD
Nephrologist

Samara Cardenas MD
Pediatric Physician

Quynh Kieu MD
Pediatric Physician

Ray Garcia Lora MD
Pediatric Physician

Raman Chopra MD
Pediatric Physician

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June 25, 2018

Dear Members of the Board of Directors, Provider Advisory Committee, and Member Advisory Committee:

I **vote in support** of lifting the cap on the auto assignment for CCN.

This cap is at odds with the mission of CalOptima to expand access to its members and increase physician participation. I am a physician located in Irvine and participate only with CCN for CalOptima. Over the last 25 years of private practice I was involved in many global volunteer missions including to Africa, South America, India and Armenia.

In 2011, after coming back from a trip I felt the need, to help with access to medical care, for families in need, in my own community of Irvine. With that thought in mind I proceeded to obtain a contract with CalOptima Direct which subsequently brought in the option of CCN. I now have several CCN patients with some complex cases like Lennox Gastaut, Infantile Spinal Muscular Atrophy, Isovaleric Acidemia to name a few.

In order to be involved, providers must have access to a wide variety of cases. A lot of our CalOptima Patients seek us out and voluntarily opt to enroll in CCN to see us. CCN must remain viable in order for providers like me to continue to offer services to the families in our community.

"The unmerited cap of 10% on CCN needs to be lifted!"

Warm regards,

Annu G Sharma MD

Past Chairman Department of Pediatrics
Hoag Hospital Newport Beach CA 92663
Chair Information Technology
American Academy of Pediatrics California Chapter
Physician of Excellence honoree 2018-2019
Orange County Medical Association
HEALTH 4 KIDZ PEDIATRIC
'Healthy kids are Happy kids'
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www.health4kidz.net

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MEMORANDUM

DATE:	December 6, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Whole-Child Model (WCM) Transition Moves to July 2019

On November 9, the Department of Health Care Services (DHCS) changed the timing of Orange County's transition of the California Children's Service (CCS) program to WCM, delaying it six months to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible member population and the complexity of our delegated delivery system, DHCS officials determined that more time is needed to ensure effective preparation for WCM implementation. Until July, CCS-eligible members in CalOptima will continue to receive CCS services from the county CCS program. On November 21, DHCS released new health network adequacy standards that more explicitly establish the number and type of CCS-paneled providers required for a health network to participate in WCM. Based on these requirements, CalOptima has a number of networks that meet the standard, several very near the goal and a few needing more progress. We immediately informed individual networks of their status and are now working to ensure more networks comply with the new requirements. Health networks not meeting the adequacy standards will not be allowed to participate in July, but they can be included at a later date after they demonstrate compliance. To ensure all members and stakeholders are aware of the revised implementation date, CalOptima initiated a significant communications effort using multiple channels, from mailed notices and a call campaign for members to emails and meetings for providers and networks. Overall, CalOptima understands and shares the state's interest in a successful transition that fulfills the original goal — integrating CCS services into Medi-Cal managed care to deliver an improved member experience and more coordinated health care that meets the needs of the whole child.

State and Federal Advocates to Discuss Midterm Elections, Mega Reg

At the December 6 Board meeting, CalOptima's state and federal advocates will provide information about the impact of the midterm elections and other regulatory changes. Don Gilbert from Edelstein Gilbert Robson and Smith will discuss Orange County's state delegation, while Eli Tomar and Geoff Verhoff from Akin Gump will detail the shift in representation at the federal level. Akin Gump is also closely monitoring upcoming revisions to the Mega Reg, the sweeping federal rule affecting Medicaid. Tomar and Verhoff will provide an impact analysis for CalOptima and share their advocacy work alongside industry associations to prepare comments on the changes by the January 2019 deadline.

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CalOptima Represented at the Top Levels of Key Industry Associations
Having access to industry association resources at a higher level will ensure CalOptima has an even greater voice and influence with policymakers. To that end, my role in three associations will be expanding. I was elected to the Board of Directors for America's Health Insurance Plans (AHIP), effective November 13. Combining public and commercial plans, AHIP is the nation's leading voice for health insurers. For Local Health Plans of California, I have moved from my role as vice chair to chair for a two-year term. Finally, on behalf of the Association for Community Affiliated Plans, I was approved as a member of the executive committee and will chair the Medicaid Policy committee on behalf of the 73 member plans for the next two years.

Program of All-Inclusive Care for the Elderly (PACE) Letter of Support Process Open
CalOptima is spreading awareness of the process for an independent PACE organization (PO) to request a letter of support, which is needed so the PO can apply to operate a PACE program in Orange County. CalOptima notified providers in a November fax blast and offered information to CalPACE, an association of PACE organizations in California. Further, we created a new page for our website and shared the link widely, including with the National PACE Association. The window to request a letter is from November 1, 2018–January 31, 2019.

Federal Regulator Considers Three-Year Extension for Cal MediConnect Program
In a November call with the Centers for Medicare & Medicaid Services (CMS), DHCS and Cal MediConnect plans, including CalOptima's OneCare Connect (OCC), learned that the federal regulator is exploring updates to the demonstration program, which are in draft form and subject to review. First is the possibility of extending Cal MediConnect beyond the December 31, 2019, end date for three years to 2022. During the extension period, CMS stated that it would likely increase the quality withhold to 4 percent rather than the current 3 percent, thus putting the plans at further risk. Also, CMS is considering a retrospective financial penalty on plans for high disenrollment rates. Finally, an experience rebate may be offered to plans as a profit-sharing mechanism if a plan achieves certain levels of cost savings. Again, these proposals are in the early stages, and health plan associations are organizing written feedback to CMS.

CalOptima Participates in Busy Medicare Marketplace With OCC Event
December is the height of open enrollment season for Medicare, and CalOptima's dual eligible members are likely receiving many messages and materials regarding enrollment in a Medicare Advantage plan. To engage our current OCC members and attract new ones, CalOptima held our first OCC Member Retention/Outreach Event at Delhi Community Center in November. We invited all OCC members as well as dual eligibles in concentrated Medi-Medi ZIP codes. Attendance at the event was good, with approximately 100 current and prospective members gathered to hear about 2019 benefits in a presentation by Maria Wahab, member outreach and education manager. This was followed by a Q&A session with CalOptima panelists specializing in customer service, pharmacy, case management and more. In addition, attendees had an opportunity to visit resource tables staffed by our health networks, vendors and community-based organizations. Based on this success, we will repeat the event next month.

Preparations Begin for Upcoming Medi-Cal Audit in February 2019
CalOptima's annual routine medical audit of Medi-Cal has been scheduled. DHCS will be on-site February 4–15, 2019, to review our compliance with contractual and regulatory requirements during the period of February 1, 2018, to January 31, 2019.

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Financial Summary

October 2018

Greg Hamblin

Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- October 2018 MTD:
  - Overall enrollment was 772,846 member months
    - Actual lower than budget 11,502 or 1.5%
      - Medi-Cal: unfavorable variance of 11,367 members
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 6,087 members
        - Medi-Cal Expansion (MCE) unfavorable variance of 4,579 members
        - Seniors and Persons with Disabilities (SPD) unfavorable variance of 648 members
        - Long-Term Care (LTC) unfavorable variance of 53 members
      - OneCare Connect: unfavorable variance of 214 members
    - 1,594 decrease from prior month
      - Medi-Cal: decrease of 1,610 from September
      - OneCare Connect: decrease of 16 from September
      - OneCare: increase of 29 from September
      - PACE: increase of 3 from September

FY 2018-19: Consolidated Enrollment (cont.)

- October 2018 YTD:
  - Overall enrollment was 3,101,661 member months
    - Actual lower than budget 37,362 members or 1.2%
      - Medi-Cal: unfavorable variance of 36,915 members or 1.2%
        - TANF unfavorable variance of 19,369 members
        - MCE unfavorable variance of 15,682 members
        - SPD unfavorable variance of 1,573 members
        - LTC unfavorable variance of 291 members
      - OneCare Connect: unfavorable variance of 717 members or 1.2%
      - OneCare: favorable variance of 257 members or 4.9%
      - PACE: favorable variance of 13 members or 1.2%

FY 2018-19: Consolidated Revenues

- October 2018 MTD:
  - ➢ Actual lower than budget $6.0 million or 2.2%
    - Medi-Cal: unfavorable to budget $2.5 million or 1.0%
      - Unfavorable volume variance of $3.7 million
      - Favorable price variance of $1.2 million
    - OneCare Connect: unfavorable to budget $3.4 million or 13.5%
      - Unfavorable volume variance of $0.4 million
      - Unfavorable price variance of $3.0 million due to Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2017 Part D true-up
    - OneCare: unfavorable to budget $188.3 thousand or 11.7%
      - Favorable volume variance of $97.2 thousand
      - Unfavorable price variance of $285.5 thousand
    - PACE: favorable to budget $37.1 thousand or 1.8%
      - Unfavorable volume variance of $7.2 thousand
      - Favorable price variance of $44.3 thousand

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FY 2018-19: Consolidated Revenues (cont.)

- October 2018 YTD:
  - Actual lower than budget $6.9 million or 0.6%
    - Medi-Cal: unfavorable to budget $6.3 million or 0.6%
      - Unfavorable volume variance of $11.9 million
      - Favorable price variance of $5.6 million due to:
        - $4.7 million of FY18 LTC revenue from non-LTC aid codes
        - $4.0 million of FY18 Coordinated Care Initiative (CCI) revenue
        - $1.7 million of FY18 Hepatitis C revenue
        - ($5.6) million of FY19 non-LTC revenue from non-LTC aid codes

FY 2018-19: Consolidated Revenues (cont.)

- October 2018 YTD:
  - OneCare Connect: favorable to budget $0.4 million or 0.4%
    - Unfavorable volume variance of $1.2 million due to enrollment adjustment
    - Favorable price variance of $1.6 million related to 2016 Quality Withhold payback
  - OneCare: Unfavorable to budget $1.2 million or 19.4%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $1.5 million due to CY 2015 risk adjustment
  - PACE: favorable to budget $0.3 million or 3.2%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.2 million

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FY 2018-19: Consolidated Medical Expenses

- October 2018 MTD:
  - ➢ Actual lower than budget $5.6 million or 2.1%
    - ▪ Medi-Cal: favorable variance of $5.8 million
      - Favorable volume variance of $3.5 million
      - Favorable price variance of $2.3 million
        - ➢ Professional Claim expenses favorable variance of $5.9 million due to Child Health and Disability Prevention Program (CHDP) and Proposition 56 expenses recorded in Provider Capitation, offset by Incurred But Not Reported (IBNR)
        - ➢ Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $2.1 million due to IBNR
        - ➢ Facilities expenses unfavorable variance of $3.5 million due to higher crossover and outpatient claims
        - ➢ Provider Capitation expenses unfavorable variance of $3.7 million due to Proposition 56 and CHDP expenses that were budgeted in Professional Claims
        - ➢ Prescription Drug expenses favorable variance of $1.0 million

FY 2018-19: Consolidated Medical Expenses (cont.)

- October 2018 MTD:
  - OneCare Connect: favorable variance of $42.7 thousand or 0.2%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $0.3 million
  - OneCare: unfavorable variance of $196.2 thousand
  - PACE: unfavorable variance of $20.5 thousand

FY 2018-19: Consolidated Medical Expenses (cont.)

- October 2018 YTD:
  - Actual lower than budget $12.7 million or 1.2%
    - Medi-Cal: favorable variance of $11.6 million
      - Favorable volume variance of $11.3 million
      - Favorable price variance of $0.3 million
        - Professional Claim expenses favorable variance of $20.2 million
        - Facilities expenses unfavorable variance of $15.0 million
        - Provider Capitation expenses unfavorable variance of $14.5 million
        - Prescription Drug expenses favorable variance of $5.7 million
    - OneCare Connect: favorable variance of $0.6 million
      - Favorable volume variance of $1.2 million
      - Unfavorable price variance of $0.6 million

- Medical Loss Ratio (MLR):
  - October 2018 MTD: Actual: 96.2% Budget: 96.1%
  - October 2018 YTD: Actual: 94.8% Budget: 95.3%

FY 2018-19: Consolidated Administrative Expenses

- October 2018 MTD:
  - Actual lower than budget $2.8 million or 21.1%
    - Salaries, wages and benefits: favorable variance of $1.5 million
    - Other categories: favorable variance of $1.3 million

- October 2018 YTD:
  - Actual lower than budget $10.7 million or 20.9%
    - Salaries, wages & benefits: favorable variance of $5.6 million
    - Purchased Services: favorable variance of $1.6 million
    - Other categories: favorable variance of $3.5 million

- Administrative Loss Ratio (ALR):
  - October 2018 MTD: Actual: 3.8% Budget: 4.8%
  - October 2018 YTD: Actual: 3.7% Budget: 4.6%

FY 2018-19: Change in Net Assets

- October 2018 MTD:
  - $2.0 million surplus
  - $4.0 million favorable to budget
    - Lower than budgeted revenue of $6.0 million
    - Lower than budgeted medical expenses of $5.6 million
    - Lower than budgeted administrative expenses of $2.8 million
    - Higher than budgeted investment and other income of $1.6 million

- October 2018 YTD:
  - $25.6 million surplus
  - $23.4 million favorable to budget
    - Lower than budgeted revenue of $6.9 million
    - Lower than budgeted medical expenses of $12.7 million
    - Lower than budgeted administrative expenses of $10.7 million
    - Higher than budgeted investment and other income of $7.0 million

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Enrollment Summary: October 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
64,015	64,443	(428)	(0.7%)	Aged	255,311	256,428	(1,117)	(0.4%)
596	620	(24)	(3.9%)	BCCTP	2,458	2,480	(22)	(0.9%)
46,935	47,131	(196)	(0.4%)	Disabled	188,036	188,470	(434)	(0.2%)
310,181	315,152	(4,971)	(1.6%)	TANF Child	1,248,996	1,263,723	(14,727)	(1.2%)
93,667	94,783	(1,116)	(1.2%)	TANF Adult	376,566	381,208	(4,642)	(1.2%)
3,429	3,482	(53)	(1.5%)	LTC	13,571	13,862	(291)	(2.1%)
237,665	242,244	(4,579)	(1.9%)	MCE	951,154	966,836	(15,682)	(1.6%)
756,488	**767,855**	**(11,367)**	**(1.5%)**	**Medi-Cal**	**3,036,092**	**3,073,007**	**(36,915)**	**(1.2%)**
14,665	**14,879**	**(214)**	**(1.4%)**	**OneCare Connect**	**58,882**	**59,599**	**(717)**	**(1.2%)**
289	**290**	**(1)**	**(0.3%)**	**PACE**	**1,134**	**1,121**	**13**	**1.2%**
1,404	**1,324**	**80**	**6.0%**	**OneCare**	**5,553**	**5,296**	**257**	**4.9%**
772,846	**784,348**	**(11,502)**	**(1.5%)**	**CalOptima Total**	**3,101,661**	**3,139,023**	**(37,362)**	**(1.2%)**

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Financial Highlights: October 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
772,846	784,348	(11,502)	(1.5%)	Member Months	3,101,661	3,139,023	(37,362)	(1.2%)
271,559,256	277,563,668	(6,004,413)	(2.2%)	Revenues	1,098,337,086	1,105,278,324	(6,941,237)	(0.6%)
261,188,770	266,806,639	5,617,869	2.1%	Medical Expenses	1,041,082,075	1,053,775,200	12,693,126	1.2%
10,414,766	13,198,471	2,783,705	21.1%	Administrative Expenses	40,325,512	50,981,219	10,655,707	20.9%
(44,280)	**(2,441,442)**	**2,397,161**	**98.2%**	**Operating Margin**	**16,929,500**	**521,905**	**16,407,595**	**3143.8%**
2,060,395	416,667	1,643,729	394.5%	Non Operating Income (Loss)	8,681,339	1,666,667	7,014,672	420.9%
2,016,115	**(2,024,775)**	**4,040,890**	**199.6%**	**Change in Net Assets**	**25,610,839**	**2,188,572**	**23,422,267**	**1070.2%**
96.2%	96.1%	(0.1%)		Medical Loss Ratio	94.8%	95.3%	0.6%	
3.8%	4.8%	0.9%		Administrative Loss Ratio	3.7%	4.6%	0.9%	
(0.0%)	(0.9%)	0.9%		Operating Margin Ratio	1.5%	0.0%	1.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: October 2018 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.1	(0.9)	6.0	Medi-Cal	19.8	5.0	14.8
(4.8)	(1.4)	(3.4)	OCC	(2.4)	(4.2)	1.8
(0.4)	(0.1)	(0.3)	OneCare	(1.3)	(0.3)	(1.0)
0.0	(0.0)	0.1	PACE	0.8	0.0	0.8
(0.0)	**(2.4)**	**2.4**	**Operating**	**16.9**	**0.5**	**16.4**
2.1	0.4	1.6	Inv./Rental Inc, MCO tax	8.7	1.7	7.0
2.1	**0.4**	**1.6**	**Non-Operating**	**8.7**	**1.7**	**7.0**
2.0	**(2.0)**	**4.0**	**TOTAL**	**25.6**	**2.2**	**23.4**

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Consolidated Revenue & Expense: October 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	518,823	237,665	756,488	14,665	1,404	289	772,846
REVENUES							
Capitation Revenue	$ 136,091,545	$ 110,454,091	$ 246,545,636	$ 21,457,919	$ 1,419,685	$ 2,136,015	$ 271,559,256
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	136,091,545	110,454,091	246,545,636	21,457,919	1,419,685	2,136,015	271,559,256
MEDICAL EXPENSES							
Provider Capitation	35,418,123	50,629,882	86,048,005	11,226,570	401,588		97,676,163
Facilities	23,187,964	23,670,684	46,858,648	3,494,523	695,246	604,273	51,652,690
Ancillary	-	-	-	767,461	69,776	-	837,237
Professional Claims	16,925,328	6,136,746	23,062,074	-	-	367,045	23,429,118
Prescription Drugs	17,615,095	20,268,875	37,883,970	5,465,037	454,076	181,487	43,984,569
MLTSS	31,579,548	2,703,703	34,283,252	1,620,102	67,956	(1,808)	35,969,501
Medical Management	1,762,028	1,126,399	2,888,426	1,148,988	54,498	667,870	4,759,782
Quality Incentives	774,166	412,842	1,187,008	281,000		2,890	1,470,898
Reinsurance & Other	471,125	561,480	1,032,604	231,511	2,416	142,280	1,408,811
Total Medical Expenses	127,733,376	105,510,610	233,243,986	24,235,190	1,745,557	1,964,037	261,188,770
Medical Loss Ratio	**93.9%**	**95.5%**	**94.6%**	**112.9%**	**123.0%**	**91.9%**	**96.2%**
GROSS MARGIN	**8,358,169**	**4,943,481**	**13,301,650**	**(2,777,271)**	**(325,872)**	**171,979**	**10,370,485**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,225,554	771,277	32,764	99,548	7,129,143
Professional fees			174,593	36,113	14,666	(259)	225,114
Purchased services			589,201	170,707	1,706	19,489	781,102
Printing & Postage			277,796	155,415	26,083	4	459,298
Depreciation & Amortization			366,624			2,072	368,695
Other expenses			1,106,600	46,538		5,187	1,158,325
Indirect cost allocation & Occupancy			(521,663)	798,228	11,794	4,731	293,089
Total Administrative Expenses			8,218,705	1,978,277	87,013	130,771	10,414,766
Admin Loss Ratio			**3.3%**	**9.2%**	**6.1%**	**6.1%**	**3.8%**
INCOME (LOSS) FROM OPERATIONS			5,082,945	(4,755,548)	(412,884)	41,207	(44,280)
INVESTMENT INCOME							2,063,843
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			12				12
CHANGE IN NET ASSETS			**$ 5,079,496**	**$ (4,755,548)**	**$ (412,884)**	**$ 41,207**	**$ 2,016,115**
BUDGETED CHANGE IN NET ASSETS			(936,963)	(1,394,773)	(75,250)	(34,456)	(2,024,775)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 6,016,460	$ (3,360,775)	$ (337,635)	$ 75,663	$ 4,040,890

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Consolidated Revenue & Expense: October 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,084,938	951,154	3,036,092	58,882	5,553	1,134	3,101,661
REVENUES							
Capitation Revenue	$ 541,401,572	$ 443,446,402	$ 984,847,974	$ 99,980,885	$ 5,128,686	$ 8,379,541	$ 1,098,337,086
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	541,401,572	443,446,402	984,847,974	99,980,885	5,128,686	8,379,541	1,098,337,086
MEDICAL EXPENSES							
Provider Capitation	143,031,220	200,904,160	343,935,379	46,689,127	1,235,988		391,860,494
Facilities	94,219,636	93,418,826	187,638,461	12,715,639	2,249,413	1,742,422	204,345,935
Ancillary	-	-	-	2,358,108	134,180	-	2,492,289
Professional Claims	65,406,859	25,797,795	91,204,654	-	-	1,640,000	92,844,654
Prescription Drugs	69,386,432	78,965,277	148,351,710	21,709,616	1,759,718	616,270	172,437,313
MLTSS	129,853,861	11,415,297	141,269,158	5,746,459	382,863	(843)	147,397,637
Medical Management	7,863,982	3,957,989	11,821,970	4,382,288	220,949	2,390,406	18,815,614
Quality Incentives	3,090,272	1,630,697	4,720,968	1,122,480		11,340	5,854,788
Reinsurance & Other	2,096,792	1,328,466	3,425,258	917,926	20,278	669,889	5,033,352
Total Medical Expenses	514,949,052	417,418,506	932,367,558	95,641,643	6,003,390	7,069,483	1,041,082,075
Medical Loss Ratio	**95.1%**	**94.1%**	**94.7%**	**95.7%**	**117.1%**	**84.4%**	**94.8%**
GROSS MARGIN	**26,452,520**	**26,027,896**	**52,480,416**	**4,339,242**	**(874,704)**	**1,310,059**	**57,255,012**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			23,472,993	3,036,889	120,676	374,449	27,005,008
Professional fees			680,879	103,003	58,667	77	842,625
Purchased services			2,504,511	722,515	52,033	43,704	3,322,763
Printing & Postage			1,177,872	279,916	31,701	21,082	1,510,570
Depreciation & Amortization			1,564,414			8,294	1,572,708
Other expenses			4,475,742	172,658	60	4,460	4,652,920
Indirect cost allocation & Occupancy			(1,182,313)	2,470,410	116,689	14,133	1,418,918
Total Administrative Expenses			32,694,097	6,785,391	379,825	466,199	40,325,512
Admin Loss Ratio			**3.3%**	**6.8%**	**7.4%**	**5.6%**	**3.7%**
INCOME (LOSS) FROM OPERATIONS			19,786,318	(2,446,149)	(1,254,529)	843,860	16,929,500
INVESTMENT INCOME							8,684,208
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			592				592
CHANGE IN NET ASSETS			**$ 19,783,450**	**$ (2,446,149)**	**$ (1,254,529)**	**$ 843,860**	**$ 25,610,839**
BUDGETED CHANGE IN NET ASSETS			4,994,353	(4,229,547)	(273,721)	30,820	2,188,572
VARIANCE TO BUDGET - FAV (UNFAV)			$ 14,789,096	$ 1,783,398	$ (980,808)	$ 813,040	$ 23,422,267

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Balance Sheet:
As of October 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$486,792,772	Accounts Payable	$13,692,368
Investments	459,590,795	Medical Claims liability	785,374,925
Capitation receivable	284,939,880	Accrued Payroll Liabilities	12,986,908
Receivables - Other	23,150,656	Deferred Revenue	86,238,097
Prepaid expenses	5,101,655	Deferred Lease Obligations	95,382
		Capitation and Withholds	122,420,262
Total Current Assets	**1,259,575,759**	**Total Current Liabilities**	**1,020,807,942**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,506,283		
505 City Parkway West	49,743,943		
	92,579,074		
Less: accumulated depreciation	(43,305,932)		
Capital assets, net	49,273,142	Other (than pensions) post employment benefits liability	25,058,410
Other Assets		Net Pension Liabilities	24,772,635
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	9,188,384	**TOTAL LIABILITIES**	**1,070,738,987**
Long-term Investments	531,840,438		
Total Board-designated Assets	541,028,822	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	541,328,822		
TOTAL ASSETS	**1,850,177,723**	TNE	83,204,015
		Funds in Excess of TNE	704,038,391
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	787,242,406
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,861,310,773**	**TOTAL LIABILITIES & FUND BALANCES**	**1,861,310,773**

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Board Designated Reserve and TNE Analysis
As of October 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	148,122,642				
	Tier 1 - Logan Circle	147,939,189				
	Tier 1 - Wells Capital	147,420,805				
Board-designated Reserve		443,482,636	312,678,371	482,342,251	130,804,265	(38,859,615)
TNE Requirement	Tier 2 - Logan Circle	97,546,186	83,204,015	83,204,015	14,342,171	14,342,171
	Consolidated:	**541,028,823**	**395,882,386**	**565,546,266**	**145,146,436**	**(24,517,443)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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HN Enrollment Summary - Medi-Cal

Health Network Name	NOVEMBER 2018	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	148,112	19.7%	22.6%
Monarch Family HealthCare (HMO16)	81,191	10.8%	12.4%
CalOptima Community Network (CN)	75,939	10.1%	11.6%
Arta Western Health Network (SRG66)	65,061	8.7%	9.9%
Alta Med Health Services (SRG69)	47,957	6.4%	7.3%
Family Choice Health Network (PHC21)	46,280	6.2%	7.0%
Kaiser Permanente (HMO04)	45,680	6.1%	7.0%
Prospect Medical Group (HMO17)	34,672	4.6%	5.3%
United Care Medical Network (SRG67)	32,543	4.3%	5.0%
Talbert Medical Group (SRG65)	24,402	3.2%	3.7%
Noble Mid-Orange County (SRG64)	24,018	3.2%	3.7%
AMVI Care Health Network (PHC58)	22,456	3.0%	3.4%
Heritage - Regal Medical Group (HMO15)	6,290	0.8%	1.0%
OC Advantage (PHC35)	2,087	0.3%	0.3%
Total Health Network Capitated Enrollment	**656,689**	**87.3%**	**100.0%**
CalOptima Direct (all others)	95,145	12.7%	
Total Medi-Cal Enrollment	**751,835**	**100.0%**	

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HN Enrollment Summary – OneCare Connect

Health Network Name	NOVEMBER 2018	Percentage
Monarch HealthCare (HMO16DB)	4,763	32.7%
Prospect Medical Group (HMO17DB)	2,518	17.3%
Family Choice Medical Group (SRG81DB)	1,775	12.2%
CalOptima Community Network (CN)	1,725	11.8%
Talbert Medical Group (SRG52DB)	1,086	7.4%
Arta Western Health Network(SRG66DB)	583	4.0%
Alta-Med (SRG69DB)	540	3.7%
United Care Medical Group (SRG67DB)	498	3.4%
Noble Mid Orange County (SRG64DB)	428	2.9%
AMVI Care Health Network (PHC58DB)	419	2.9%
Heritage - Regal Medical Group (HMO15)	194	1.3%
OC Advantage (PHC35DB)	57	0.4%
Total OneCare Connect Enrollment	**14,586**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	NOVEMBER 2018	Percentage
Monarch HealthCare (PMG53DE)	670	47.3%
AMVI/Prospect Medical Group (PMG27DE)	290	20.5%
Talbert Medical Group (PMG52DE)	125	8.8%
Arta Western Health Network (PMG66DE)	101	7.1%
Family Choice Medical Group (PMG21DE)	86	6.1%
Alta-Med (PMG69DE)	77	5.4%
United Care Medical Group (PMG67DE)	43	3.0%
Noble Mid Orange County (PMG64DE)	25	1.8%
Total OneCare Enrollment	**1,417**	**100.0%**

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Orange County Legislative Delegation

November 6, 2018 Election Results

U.S. CONGRESS

Congressional District (7)	General Election Results
CD 38 – Linda Sánchez (D)	Linda Sánchez (D)
CD 39 – Ed Royce (R) *(Retiring)*	**Gil Cisneros (D)**
CD 45 – Mimi Walters (R)	**Katie Porter (D)**
CD 46 – Lou Correa (D)	Lou Correa (D)
CD 47 – Alan Lowenthal (D)	Alan Lowenthal (D)
CD 48 – Dana Rohrabacher (R)	**Harley Rouda (D)**
CD 49 – Darrell Issa (R) *(Retiring)*	**Mike Levin (D)**

STATE SENATE

Senate District (5)	General Election Results
SD 29 – Ling-Ling Chang (R)	Current term to 2020
SD 32 – Vanessa Delgado (D)	**Bob Archuleta (D)**
SD 34 – Janet Nguyen (R)	**Tom Umberg (D)**
SD 36 – Pat Bates (R)	Pat Bates (R)
SD 37 – John Moorlach (R)	Current term to 2020

STATE ASSEMBLY

Assembly District (7)	General Election Results
AD 55 – Phillip Chen (R)	Phillip Chen (R)
AD 65 – Sharon Quirk-Silva (D)	Sharon Quirk-Silva (D)
AD 68 – Steven Choi (R)	Steven Choi (R)
AD 69 – Tom Daly (D)	Tom Daly (D)
AD 72 – Travis Allen (R) *(Did not file for re-election)*	**Tyler Diep (R)**
AD 73 – William Brough (R)	William Brough (R)
AD 74 – Matthew Harper (R)	**Cottie Petrie-Norris (D)**

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ORANGE COUNTY BOARD OF SUPERVISORS

District (5)	General Election Results
DIS 1 – Andrew Do	Current term to 2020
DIS 2 – Michelle Steel	Michelle Steel
DIS 3 – Todd Spitzer	Elected as Orange County District Attorney *A special election for Dis. 3 will be held early next year to fill this seat for the remainder of the term, ending in 2020.*
DIS 4 – Shawn Nelson *(Termed out)*	**Doug Chaffee**
DIS 5 – Lisa Bartlett	Lisa Bartlett

Bold = Newly Elected

Last updated: December 3, 2018, 11:00 a.m.

Source: *https://vote.sos.ca.gov*

About CalOptima

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

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

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Intergovernmental Transfer (IGT) Funding Update

Provider Advisory Committee

December 13, 2018

Cheryl Meronk, Director, Strategic Development

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Agenda

- Background: CalOptima Share of IGT Funding
- Impact of Final Rule
- Fiscal Impact of IGT 8 & 9
- Potential Strategic Areas for IGT 8 & 9
- Summary

Background: CalOptima Share of IGT Funding

IGT Number	Funding Year	CalOptima Share	Key Points
1	2010-11	$12.8M	• IGT 1-7 implemented prior to federal Medicaid and CHIP Final Rule
2	2011-12	$8.7M	
3	2012-13	$4.9M	
4	2013-14	$7.0M	
5	2014-15	$14.4M	
6	2015-16	$15.2M	
7	2016-17	$15.9M	
8 (est.)	2017-18	$43.2M	• Effective July 2017, the Final Rule prohibits retrospective payments to Medicaid managed care plans • DHCS implemented a new payment model for IGT funding
9 (est.)	2018-19	$45.6M	

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Impact of Final Rule

	IGT 1 – 7	IGT 8 and After
Purpose	To enhance the health of Medi-Cal members we serve	To enhance Medi-Cal covered services
Rate	Retrospective calculation of Medi-Cal costs for prior rate years	Prospective payment model; included in our capitation rates from DHCS for the current year
Permitted Use	Fund enhanced services not already paid for or provided under our DHCS contract	Must be tied to Medi-Cal covered services provided under our DHCS contract
Operations	Reflected below the line and considered a pass through payment; no impact on the regular income statement	Part of our operating income and expenses and can plan during our normal budget process

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Fiscal Impact of IGT 8 & 9

Description	FY 2017-18	FY 2018-19 Budget
Consolidated Revenue without IGT	$3.45B	$3.46B
IGT Revenue (Funding Partners & CalOptima)	$0.13B	$0.14B
Total Revenue including IGT	$3.58B	$3.60B
CalOptima Share of IGT Funding	$0.04B	$0.05B
% CalOptima IGT/ Total Revenue	*1.2%*	*1.3%*

- IGT 8 & 9 is drastically different from previous IGTs as it will include:
  - ACA funding formula for the Medicaid Expansion population (i.e., 95/5 federal/state split)
  - ACA enhanced federal funding for the CHIP population (88/12 federal/state split)

Potential Strategic Areas for IGT 8 & 9

- Starting with IGT 8
  - Must be used for Medi-Cal covered services included in CalOptima's DHCS contract
    - We already pay for contracted Medi-Cal services
    - Funding is not eligible to be used for non-contracted Medi-Cal services
    - Funding is not eligible for services that are NOT included in CalOptima's DHCS contract; has to be used for contracted services
  - Funding can be used to pay for contracted Medi-Cal services through:
    - Multi-year strategic provider rate changes
    - Increased funding of incentive programs/payouts
  - Advantage of increasing funding to existing incentive programs: Drive outcomes that improve quality of care for members
    - Increase member satisfaction
    - Direct provider behavior and improve outcomes

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Summary

- IGT 8 and 9
  - Funding has to be:
    - Used for Medi-Cal members
    - Tied to Medi-Cal covered services included in CalOptima's DHCS contract
  - DHCS is not allowed to direct CalOptima's expenditure of the IGT payments
  - CalOptima will record IGT revenues and expenses as part of our Income and Expense
    - IGT funds were considered a pass through in prior years
  - IGT is authorized only one year at a time
    - Subject to change or potential elimination by DHCS
  - IGT expenditures need to be for a limited time and amount
  - Strategic funding in order to maximize impact to CalOptima's members
    - Increase member satisfaction and access to care

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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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CHOC Children's

Mental Health Initiative Overview

December 13, 2018

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To nurture, advance and protect the health and well-being of children.

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The problem:

- OC population 3.1 million
- 32 inpatient psychiatric beds
- One per 22,000 children
- CA has one per 13,924
- No beds for children under 12
- Fewer licensed mental health professionals than
- Lack of mental health care coordination

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"CHOC's efforts make me hopeful that parents of children with mental health conditions will be able to access a world-class pediatric center for excellence right here in Orange County."

Kay Warren
Co-Founder,
Saddleback Church

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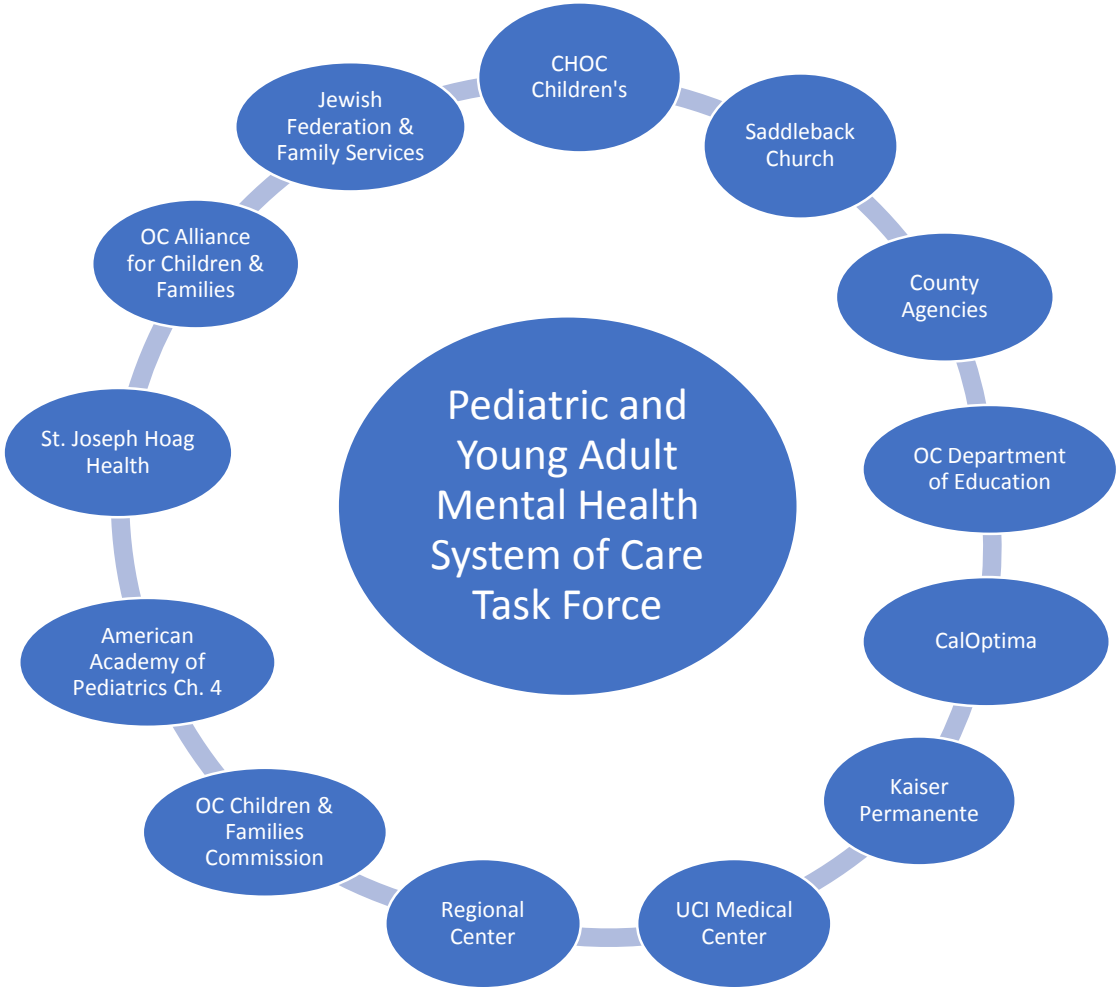

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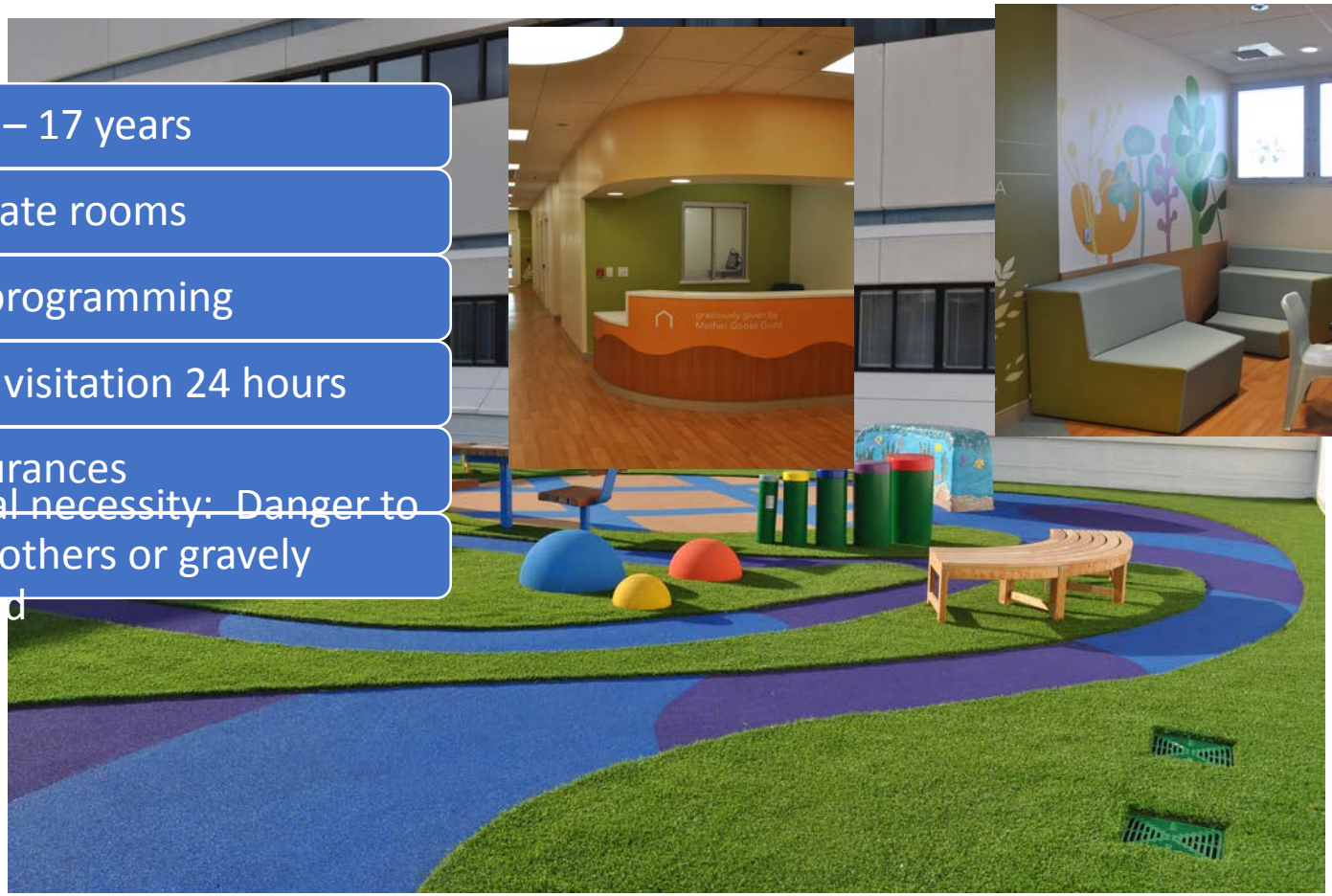
CHOC Mental Health Inpatient Unit

- Ages 3 – 17 years
- 18 private rooms
- 7 day programming
- Parent visitation 24 hours
- All insurances
- Medical necessity: Danger to self or others or gravely



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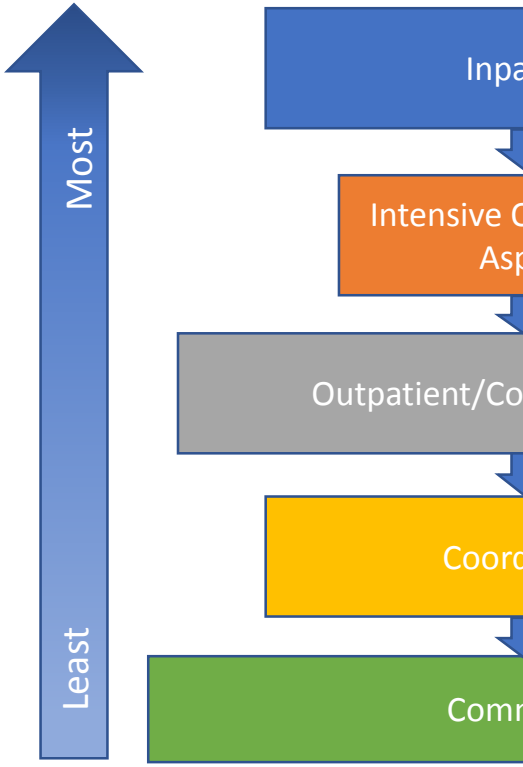
Pediatric and Adolescent Mental Health System of Care Model



- **Inpatient** — Mental Health Inpatient Center, consultation/ liaison for medical units
- **Intensive Outpatient: Aspire** — ASPIRE (IOP), Project Health (FSP)
- **Outpatient/Co-Occurring Clinic** — Co-occurring Clinic, outpatient therapy, ED Triage Program, outpatient psychiatry clinics, embed mental health in medical clinics
- **Coordination** — Resource Specialists; Psychiatric Access Line
- **Community** — Education of pediatricians & teachers, UniHealth Grant, Early Childhood Mental Health Program

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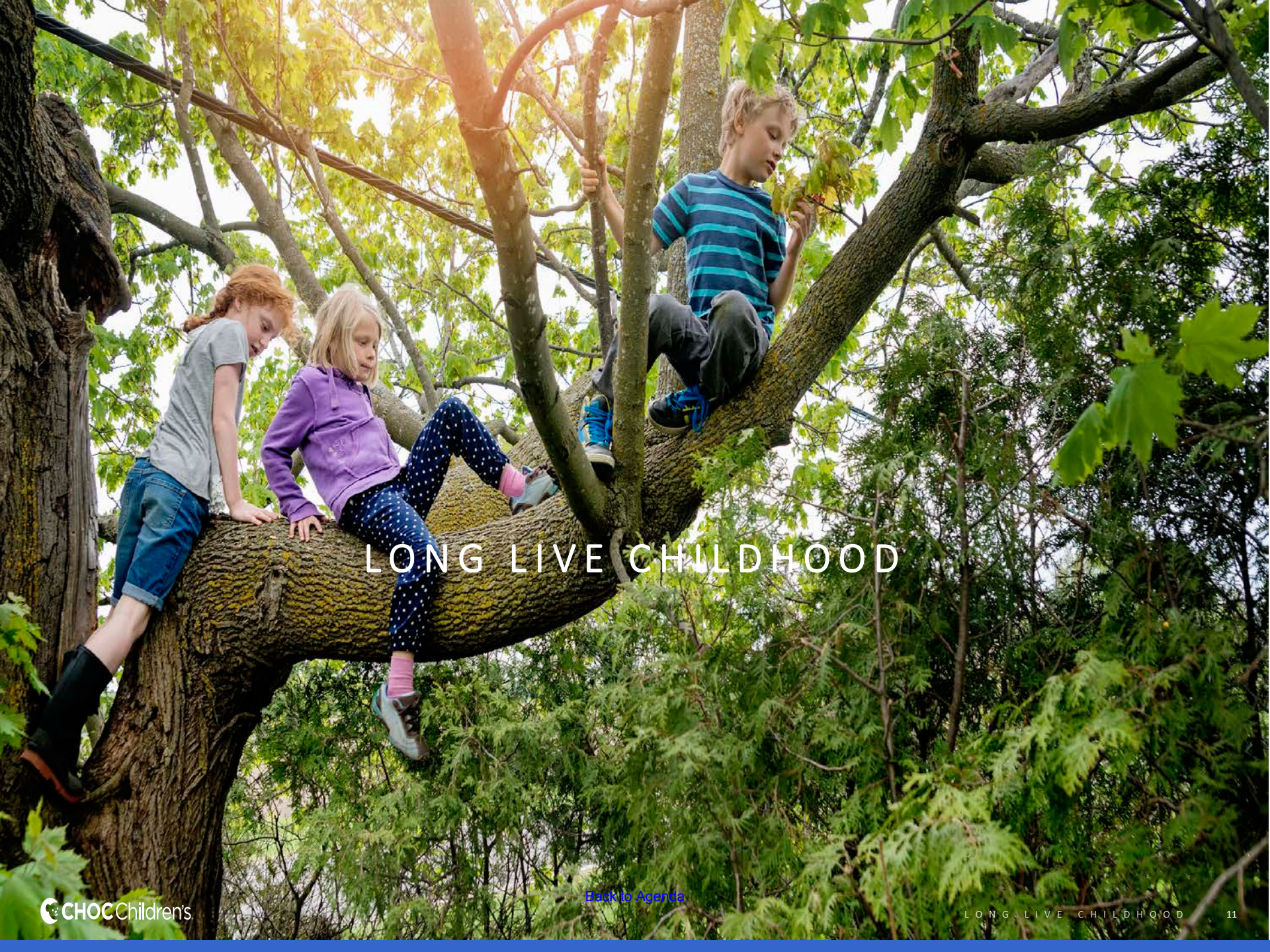

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