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

THURSDAY, OCTOBER 27, 2016
3:00 P.M.

CALOPTIMA
505 CITY PARKWAY WEST, SUITE 109-N
ORANGE, CALIFORNIA 92868

AGENDA

This agenda contains a brief, general description of each item to be considered. The Committee may take any action on all items listed. Except as otherwise provided by law, no action shall be taken on any item not appearing in the following agenda.

Information related to this agenda may be obtained by contacting the CalOptima Clerk of the Board at 714.246.8806 or by visiting our website at www.caloptima.org. In compliance with the Americans with Disabilities Act, those requiring special accommodations for this meeting should notify the Clerk of the Board's office at 714.246.8806. Notification at least 72 hours prior to the meeting will allow time to make reasonable arrangements for accessibility to this meeting.

I. CALL TO ORDER
Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES
A. Approve Minutes of the September 22, 2016 Meeting of the OneCare Connect Member Advisory Committee (OCC MAC)

IV. PUBLIC COMMENT
At this time, members of the public may address the Committee on general topics. Public Comment on posted item(s) will follow staff presentation of the item(s) to the Committee. If you wish to speak on an item contained in the agenda, please complete a Public Comment Request Form(s) identifying the item(s) and submit the form to the assistant to the OneCare Connect MAC. 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 Medical Officer Update

VI. INFORMATION ITEMS

A. Community-Based Adult Services (CBAS) Statistics and Trends
B. Hospice Benefit for OneCare Connect Members
C. Federal and State Legislative Update
D. OneCare Connect Member Enrollment Update
E. OneCare Connect Update
F. OCC MAC Member Presentation on Orange County Aging Report and Strategic Plan
G. OCC MAC Member Updates

VII. COMMITTEE MEMBER COMMENTS

VIII. ADJOURNMENT

MINUTES

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

September 22, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on September 22, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:02 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Gio Corzo, Josefina Diaz, John Dupies, Susie Gordee, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Adam Crits (non-voting), Erin Ulibarri (non-voting)

Members Absent: Sandy Finestone, Donta Harrison, Jorge Sole (non-voting)

Others Present: Michael Schrader, Chief Executive Officer, Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Affairs; Albert Cardenas, Associate Director, Customer Service; Dr. Donald Sharps, Medical Director, Medical Management; Tracy Hitzeman, Interim Executive Director, Clinical Operations; Becki Melli, Staff to OCC MAC

MINUTES

Approve the Minutes of the August 25, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Gio Corzo, seconded and carried, the OCC MAC approved the August 25, 2016 minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Recommendation for OCC MAC Chair and Vice Chair
Chair Mouton reported that following the Board's approval of the addition of a vice chair on the committee, OCC MAC opened nominations for the OCC MAC chair and vice chair positions. OCC MAC received one interested candidate for each position. Patty Mouton, Home and

Community-Based Services (HCBS) Representative Serving Seniors, applied for the chair position and Gio Corzo, Community-Based Adult Services (CBAS) Provider Representative, applied for the vice chair position. The Nominations Ad Hoc, consisting of members Lena Berlove, Sandy Finestone and Erin Ulibarri, recommended the committee consider these candidates for Board consideration.

Action: ***On motion of Member Ted Chigaros, seconded and carried, the OCC MAC recommended Patty Mouton as the OCC MAC Chair, and Gio Corzo as the OCC MAC Vice Chair for the remainder of FY 2016-2017.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Update

Michael Schrader, Chief Executive Officer, announced that the National Committee for Quality Assurance (NCQA) reported its quality ratings for Medicaid plans on September 20, 2016. CalOptima is California's top-rated Medi-Cal plan for the third year in a row, according to the NCQA's Medicaid Health Insurance Plan Ratings 2016-2017. CalOptima received a score of four out of five, the highest score awarded to any Medi-Cal plan in California. Only 15 of the 171 Medicaid plans reviewed nationwide scored higher. CalOptima's accreditation status went from 'accredited' to 'commendable'.

Chief Medical Officer (CMO) Update

Donald Sharps, M.D., Medical Director, provided a brief update on the Managed Behavioral Health Organization (MBHO) Request for Proposal (RFP) process. On September 1, 2016, the CalOptima Board of Directors authorized staff to enter into a contract with Magellan Health Inc., within 30 days to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare Connect members effective January 1, 2017. It was noted that Applied Behavior Analysis (ABA) services are included in the MBHO.

INFORMATION ITEMS

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

Rena Smith, Director, PACE, presented an overview of the PACE program, including eligibility requirements, services provided, and the role of PACE in the continuum of care. She explained that PACE is a community-based program that provides all necessary medical and social services to seniors, noting that it offers seniors an opportunity to stay in their homes and maintain their independence. An Interdisciplinary Team (IDT) composed of eleven health care professionals provides individualized care for each PACE participant. Ms. Smith noted that the PACE center is the first and only PACE program in Orange County, with California having 13 PACE programs in total.

OneCare Connect Member Enrollment Update

Albert Cardenas, Associate Director, Customer Service, provided an update on the current OneCare Connect enrollment. As of September 14, 2016, enrollment was 17,750. The top three health networks with the highest enrollment were Monarch, Prospect Medical Group, and CalOptima Community Network. There were 181 OneCare Connect members in a deeming status, as of September 12, 2016.

Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported that CalOptima staff is in the process of developing the proposed 2017-2018 legislative platform. Staff will reach out to the advisory committees for input before presenting the proposed platform to the CalOptima Board for consideration.

OCC MAC Member Presentation on Legal Aid Society of Orange County

Member Josefina Diaz, Litigation Paralegal, Legal Aid Society of Orange County (LASOC), presented an overview of her agency. LASOC provides free civil legal service to low income residents of Orange County who are at or below the poverty level. The LASOC is a non-profit corporation funded by the Legal Services Corporation in Washington D.C, and by public and private sources. Ms. Diaz reported that LASOC handles the following types of cases: family; landlord/tenant; government benefits; education; consumer problems; bankruptcy; and health advocacy. LASOC also manages certain programs and services for seniors, the homeless, and health consumers. The Legal Hotline provides legal counseling and advice on a wide range of legal issues.

OCC MAC Member Updates

Chair Mouton reminded the Committee to complete the mandatory CalOptima Annual Compliance Training required by the Centers for Medicare & Medicaid Services (CMS) and other regulatory agencies. The deadline for completion is November 4, 2016.

Chair Mouton also reminded the Committee of the importance of attending OCC MAC meetings. She added that Committee members should RSVP before the meeting so staff knows if there will be a quorum. Chair Mouton noted that the November OCC MAC meeting is on November 17, 2016, due to the Thanksgiving holiday. In response to Chair Mouton's request for future OCC MAC agenda items, suggestions included information on long-term care and hospice care.

Chair Mouton announced that the next OneCare Connect MAC meeting is October 27, 2016 at 3:00 p.m.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 3:53 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 10.27.2016

MEMORANDUM

DATE:	October 6, 2016
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

California Children's Services (CCS) Program
On September 25, Gov. Brown signed SB 586 into law, authorizing implementation of the Whole Child Model (WCM) for the CCS program no earlier than July 1, 2017. In selected counties, including Orange, this will transition CCS from a fee-for-service system run by counties to a benefit administered by Medi-Cal managed care plans. CalOptima will be responsible for providing most CCS services to approximately 11,810 members. We will also be responsible for establishing a local stakeholder process, including two new advisory committees. Many of the CCS services currently administered by the Orange County Health Care Agency will transition to CalOptima, such as care coordination, case management, service authorizations and provider referrals. However, some services will continue to be carved out of the WCM, such as CCS eligibility determinations, Medical Therapy Unit services and neonatal intensive care services. SB 586 also spells out other provisions of the transition, such as member notices, continuity of care rules and reporting requirements. During the past several months, CalOptima has been actively collaborating with state regulators and county officials to prepare for the change. We will keep your Board informed about our progress, as CalOptima works to ensure Orange County's CCS children experience a smooth transition.

National Committee for Quality Assurance (NCQA) Rating
CalOptima is California's top Medi-Cal plan for the third year in a row, according to the NCQA's Medicaid Health Insurance Plan Ratings 2016–2017. CalOptima received a score of 4 out of 5 — the highest score awarded to any Medi-Cal plan in the state. Further, only 15 Medicaid plans of the 171 reviewed nationwide scored higher. The ratings are based on three major performance categories: consumer satisfaction, prevention and treatment. CalOptima shared news about our top-plan status with our employees and community widely, using a variety of communications channels, including press releases, social media postings, emailed memos and an electronic newsletter. Health network partners, providers, community-based organizations and elected officials all received our message, and the congratulatory responses were gratifying! We will continue spreading the word using a custom graphic and tagline of "CalOptima Qualityx3: Top Medi-Cal Plan in California Three Years and Counting!"

Program of All-Inclusive Care for the Elderly (PACE)
CalOptima PACE enjoyed two successes in September: a positive regulatory audit and a proposed rate increase. On September 1, PACE completed its third audit in three years with good

results. The auditors' preliminary findings showed that out of 14 elements (four operational and 10 clinical), PACE met 11. Three elements had findings:

- Transportation: Prior to the audit, PACE self-disclosed issues with the transportation program for exceeding the one-hour time limit.
- Infection Control: The glucometer disinfection process was deemed out of compliance with manufacturer recommendations.
- Quality: This finding also involved transportation and the level of oversight of the transportation vendor.

A final report is due in early October, and PACE will have 30 days to respond with a corrective action plan. Overall, the auditors were complimentary about our center and staff, noting that the program has come a long way in three years. Separately and for some time, CalOptima has been advocating for better PACE rates, based on the fact that our rates are among the lowest in the state. On September 20, the Department of Health Care Services (DHCS) responded with an increase to the PACE Medi-Cal rate for Calendar Year 2016. These rates are preliminary and awaiting federal approval. Our finance team is in the process of assessing the new rate's impact on overall financial performance. Medi-Cal represents about 68 percent of total PACE revenue, and the rest is Medicare. CalOptima is also taking an active approach to boosting PACE Medicare revenue by more fully capturing and reporting the acuity of our dual eligible PACE participants. I will keep your Board informed as the financial status of PACE crystallizes.

Strategic Plan

Work on CalOptima's next three-year strategic plan will continue with a special Board strategic planning session on Thursday, November 3, immediately following the regular Board meeting. Bobbie Wunsch of Pacific Health Consulting Group will facilitate the session, and DHCS Director Jennifer Kent will be guest speaker. To prepare, I plan to meet with individual Board members this month to lay the groundwork for the session and share the draft framework of the strategic plan that staff previously developed with Ms. Wunsch. After the November 3 session, the goal is to bring a final strategic plan for approval at your December meeting.

Key Meetings

- UCI Health: On September 2, as part of a continuing series of quarterly meetings, Dr. Richard Helmer, Ladan Khamseh and I met with the leadership team from UCI Health, including CEO Howard Federoff, CFO Jay Sial and others. Leaders are interested in increasing UCI's collaboration with CalOptima in the area of population health.
- Orange County Business Council (OCBC) Board of Directors: The OCBC is a leading organization in the local business community. I serve on the Board along with a number of other health care leaders from organizations such as CHOC and UCI. Monthly Board meetings address a variety of business topics, often including issues in the health care industry. The September 8 meeting touched on the tobacco tax initiative, which is on the November ballot and may help increase funding for Medi-Cal.
- Regional Center of Orange County (RCOC): On September 9, Dr. Helmer, Dr. Donald Sharps and I met with RCOC leaders to share an update regarding the transition of Applied Behavior Analysis services from RCOC to CalOptima Medi-Cal. From February to September, nearly 1,300 children have transitioned, and the process is nearly complete, with fewer than 100 children remaining to be transitioned.

- Health Network Leadership Meeting: On September 20, CalOptima executives and network management staff met with 18 leaders from our contracted health network partners. The agenda included discussion of CalOptima's financial reserve requirements and upcoming audit of networks' medical loss ratio along with updates about quality and compliance issues. These CalOptima-network leadership meetings are tentatively planned to continue on a quarterly basis.
- Hospital Association of Southern California (HASC): On September 22, I facilitated a group discussion about patient education, navigation and coordination at the third HASC-sponsored Medi-Cal Task Force meeting. The group agreed that better patient education and care coordination leads to appropriate use of emergency rooms and prevents readmissions. To that end, I shared some of CalOptima's efforts in educating new moms, because the highest use of emergency rooms is in infants and children up to age 2, and in planning better hospital discharges, which prevents readmission. The participants discussed activities at their organizations and ideas for collaboration between hospitals and health plans. The task force meetings gather leaders from Southern California hospitals, public managed care plans and providers to create recommendations that will improve local delivery systems, develop a common policy agenda and forge an advocacy platform for HASC to use at the state level. The final task force meeting this month will summarize ideas from prior meetings and establish next steps.

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Community-Based Adult Services Statistics and Trends: 2012–Present

OneCare Connect Member Advisory Committee

October 27, 2016

Cathy Osborn, MSRC, CBAS Program Manager

Marsha Petersen, RN, Manager, Long-Term Services and Supports

Community-Based Adult Services (CBAS) Utilization

- CalOptima began administering the CBAS benefit in July 2012. An average of 2,077 members received CBAS during first quarter* (Q1) after implementation (Q3, 2012).
- The number of CalOptima members receiving CBAS peaked at 2,367 in Q1, 2014.
- The number of CalOptima members receiving CBAS fell to 1,962 in Q4, 2015.
- Currently, an average of 2,032 CalOptima members are receiving CBAS.

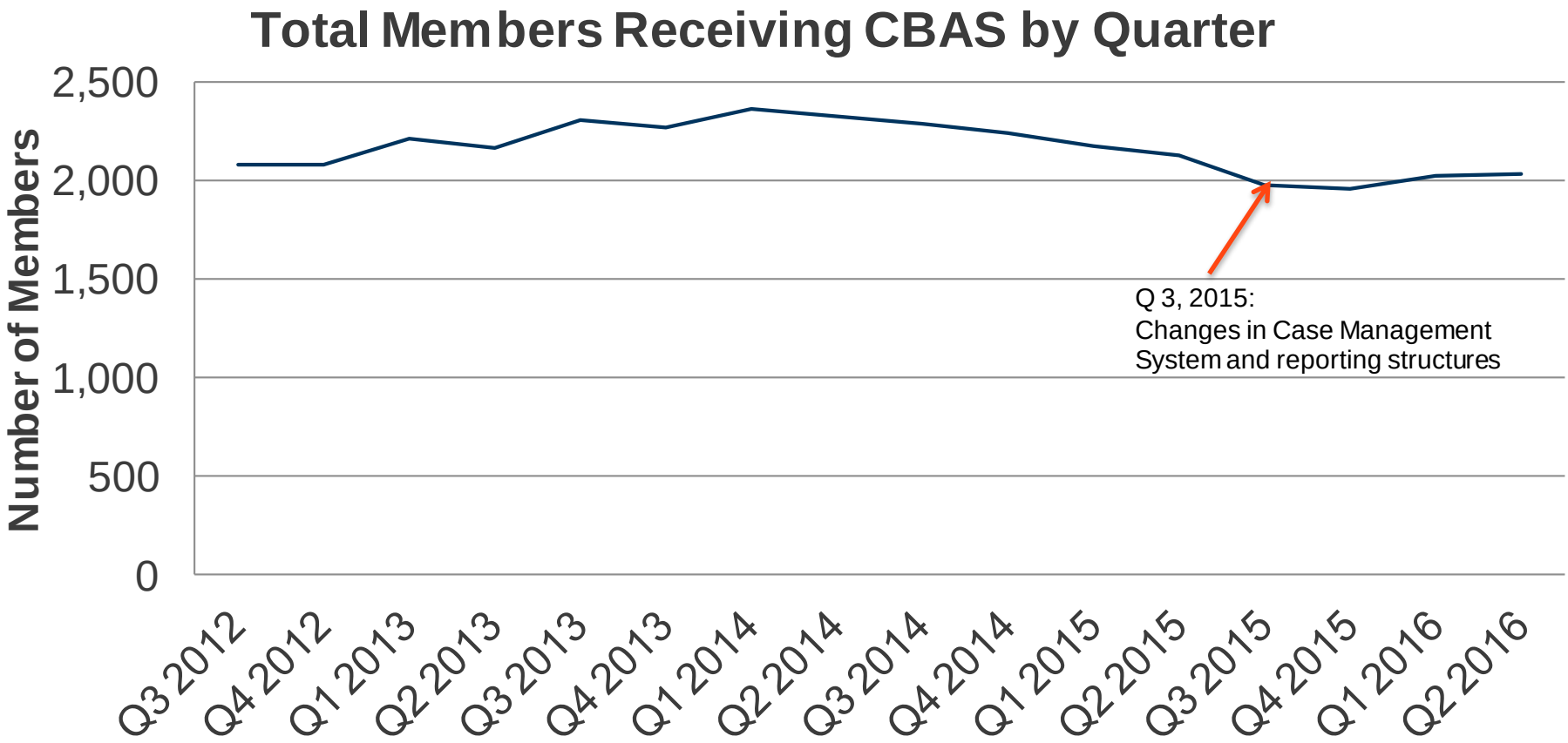
* All instances of quarters refer to the calendar year.

CBAS Utilization (cont.)

- Q3, 2015: CalOptima implemented a new case management system:
  - As a result, we have better opportunities for reporting.
- Q3, 2015: CalOptima also changed how CBAS members are identified for reporting purposes:
  - As a result, we have a more accurate count.

* All instances of quarters refer to the calendar year.

CBAS Utilization (cont.)

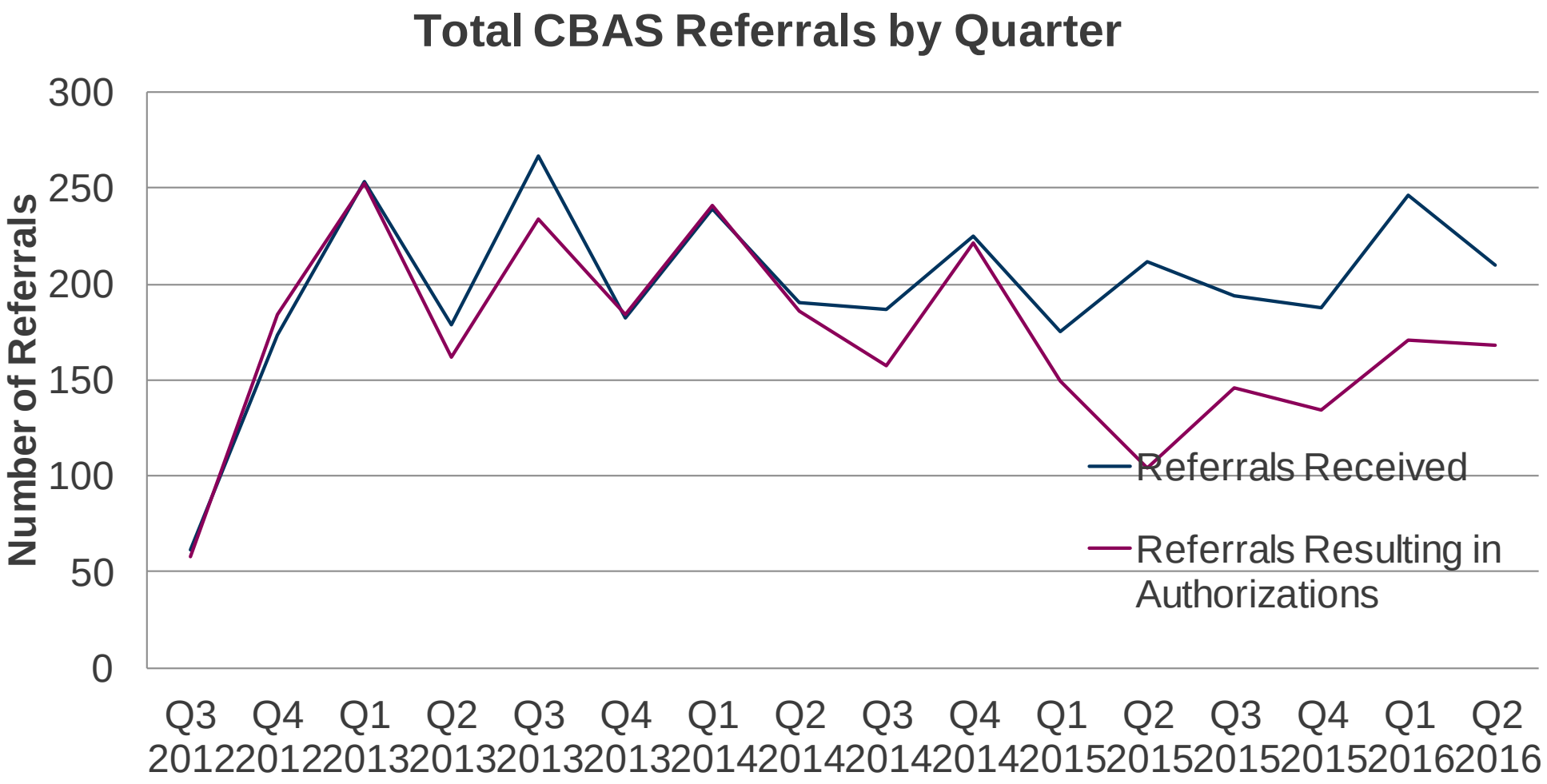


* All instances of quarters refer to the calendar year.

CBAS Referrals and Sources

Year	2012		2013				2014				2015				2016	
Quarter	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Total	**61**	**173**	**253**	**179**	**267**	**182**	**239**	**190**	**187**	**225**	**175**	**212**	**194**	**188**	**246**	**210**
CBAS	59	157	230	160	239	166	224	170	181	208	165	184	176	177	234	195
Physician	1	1	1	0	2	0	0	0	0	0	0	0	1	2	1	1
Internal	1	4	13	5	8	2	1	2	1	2	0	13	17	9	9	14
Member/ Family	7	8	7	10	6	5	9	4	1	1	0	0	0	0	0	0
Board & Care	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital	0	1	0	2	3	1	0	1	0	0	0	0	0	0	0	0
Other Community-Based Organizations	0	1	0	5	5	7	9	6	1	14	6	15	0	0	2	0
Nursing Facility	0	0	0	0	0	0	0	2	0	0	3	0	0	0	0	0

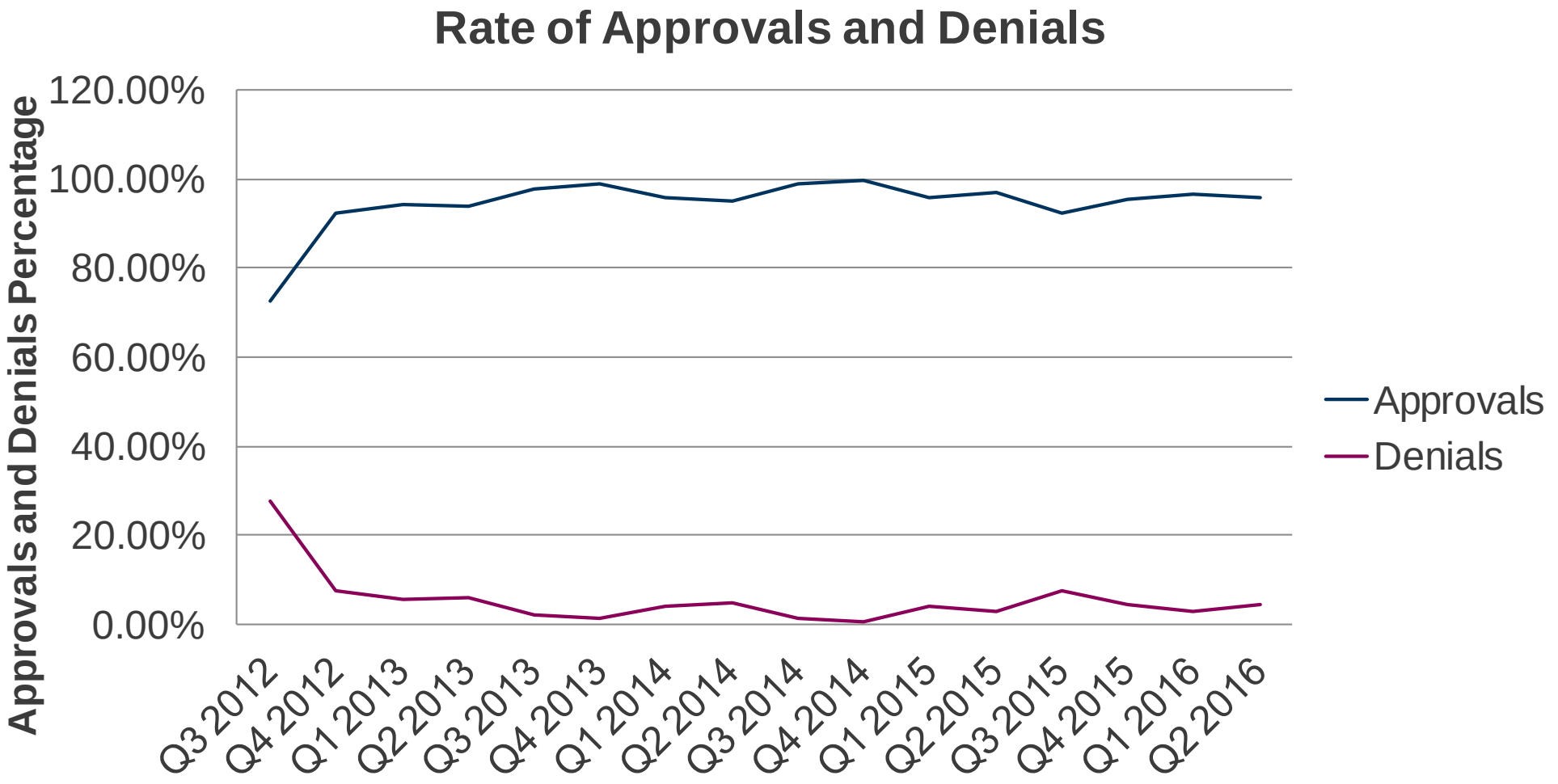
CBAS Referrals



CBAS Approvals and Denials

- Ratings calculated using the number of Initial CBAS authorizations (approvals and denials).
- Not all referrals advance to an eligibility screening:
  - Members don't meet pre-screen criteria, i.e. 18 years or older.
  - Members withdraw their request for CBAS. For example, of the 210 referrals received in Q2, 2016, 42 were closed because member changed their mind or we were unable to contact member.
- Average approval rating: 94.53%.
- Average denial rating: 5.44%.

CBAS Approvals and Denials (cont.)

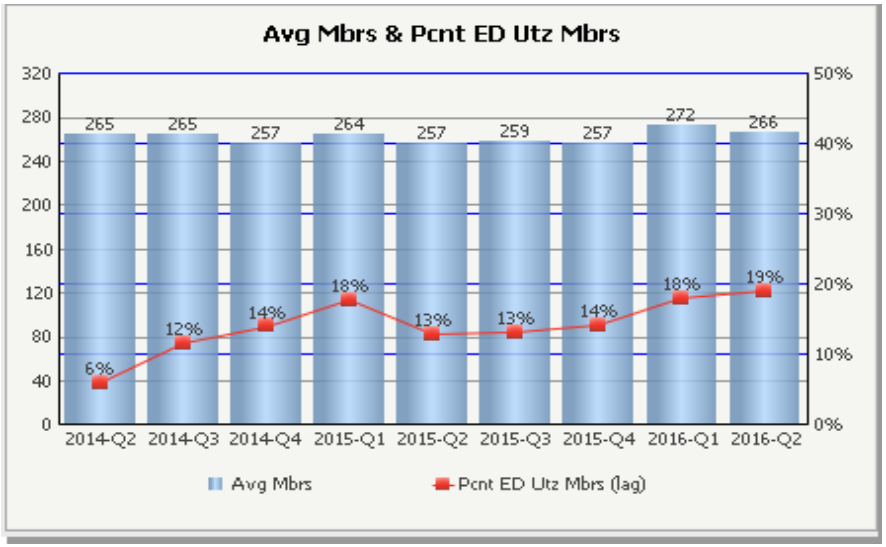


CBAS Members, Emergency Department (ED) and Inpatient (IP) Utilization

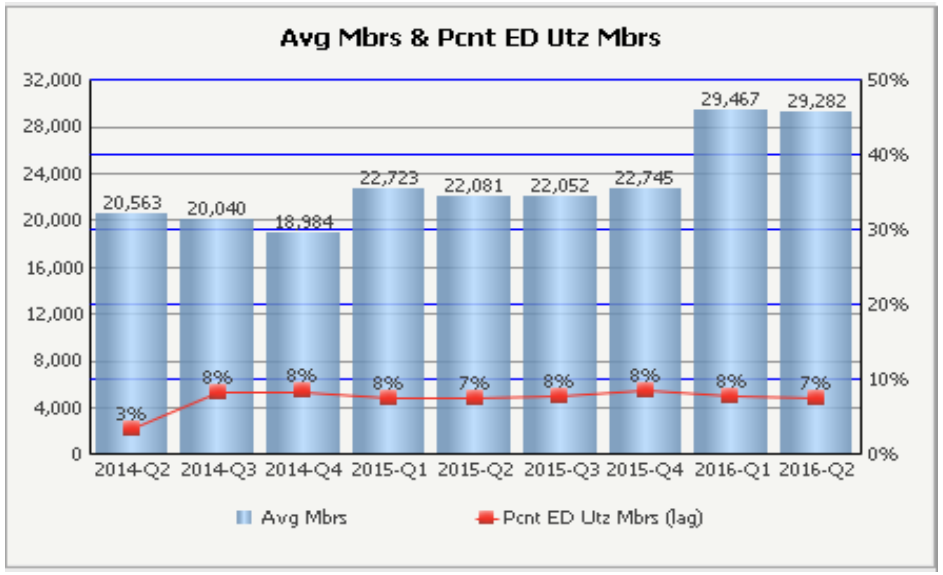
- On average, CBAS members have more diagnoses and higher acuity levels than general population (GP).
- CBAS members have regular nursing oversight at the CBAS center.
- ED and IP utilization, on average, are higher than GP
  - Problems requiring ED visits are being recognized earlier by CBAS staff.
  - As a result, CBAS members are referred to ED more frequently than general population.
  - Even though CBAS members visit ED more often, admission rates are only slightly higher than GP for this high risk group.

ED Utilization

CBAS



General Population



Age 65+
Excludes dual plan members

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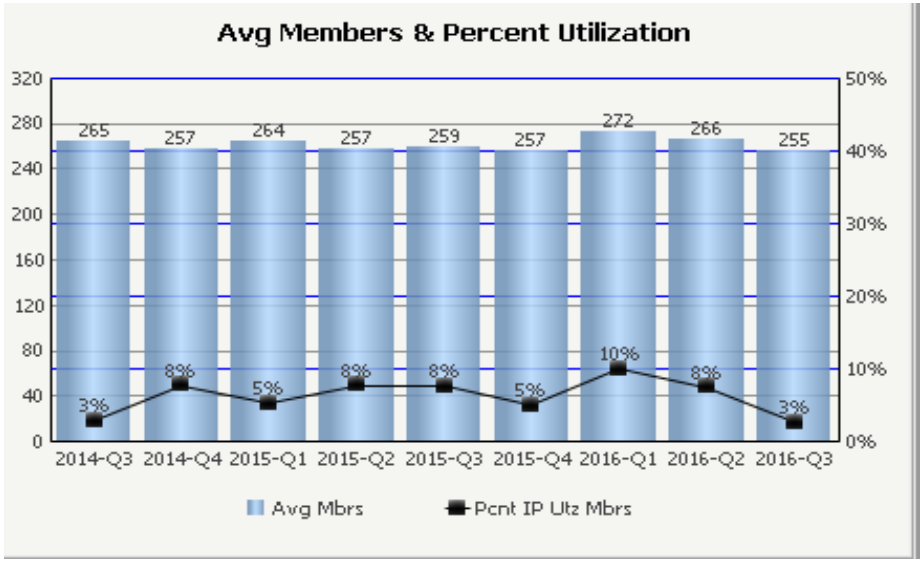
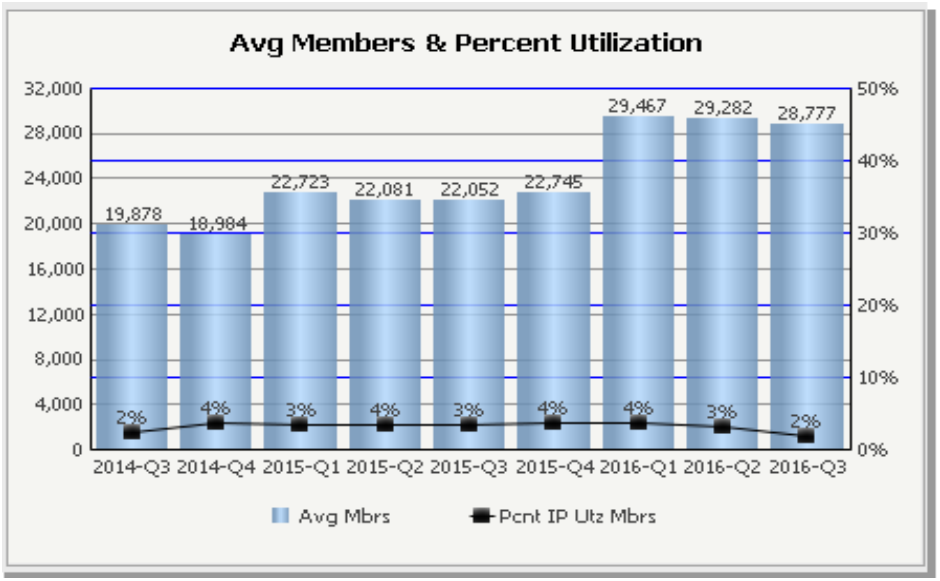
Inpatient Utilization

CBAS



General Population



Age 65+
Excludes dual plan members

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CBAS Quality Oversight

- Quality oversight process by CalOptima quality review nurse specialist (QI nurse) — implemented in 2014
- QI nurse visits each center at least one time per year.
- Assess compliance of contracted CBAS centers
- Monitors California Department of Aging (CDA) CBAS certification standards
  - Faculty
  - Administration
  - Staff
  - Services
  - Participant care

CBAS Quality Oversight (cont.)

- Administers Corrective Action Plans
- Monitors Plan of Corrections
- Regular follow up via visits, email and phone

Most Frequently Cited Findings: 2016

- Services:
  - Failure to provide evidence of liaison with primary care provider (PCP) to provide or obtain medical information related to participant status or care
  - Medication administration without time notation
- Participant care:
  - Failure to provide evidence that services and/or interventions were provided as specified by Individual Plan of Care (IPC)
  - Failure to ensure IPC meets the needs of the participant

Interventions

- Root Causes:
  - Unaware of regulatory requirements
  - Staff turnover
  - Transition to new electronic medical records computer software
- Interventions:
  - In-services and staff re-training
  - Regrouping of multidisciplinary team to discuss underdeveloped care plans
  - Improvements to and/or additions of necessary problems and interventions to the care plan

Outcomes

- Better developed care plans
- Improvement in monitoring and managing disease processes
- Improvement in documentation of services rendered as specified by IPC
- Updated and improved flow sheets
- CBAS compliance in accordance with:
  - CalOptima contract
  - CBAS Certification Standards
  - CBAS Standards of Participation
  - Welfare and Institutions Codes
  - Title 22 Regulations

CBAS Satisfaction Survey

- Annual satisfaction survey implemented in 2014
- Administered by CBAS centers
- CalOptima survey or CBAS-generated survey used
- Members and/or caregivers surveyed

CBAS Satisfaction Survey Results

- 2014
  - Thirty CBAS centers surveyed.
    - Average rating: 95.8%
    - Lowest rating: 85.0%
    - Six CBAS centers with a rating of 100%
- 2015
  - Twenty-nine CBAS centers surveyed
    - Average rating: 98.1%
    - Lowest rating: 91.3%
    - Nine CBAS centers with a rating of 100%

Improvement Opportunities

- Questions that received the most feedback:
  - CBAS is not neat and clean
  - Transportation issues
  - Not satisfied with the meals
  - If you have a complaint about something, do you feel you can voice it and it is addressed

Improvement Highlights

- Reach out to a separate transportation company to open up more pickup and drop off times
- Caterer changed
- Participants now have option of alternate meal (i.e., soup and crackers or prior day's menu)
- Suggestion box implemented for participants and caregivers to anonymously submit concerns. "Open Door" policy announced at center's open house and letter reiterating this, also mailed to participants and their families

Improvement Highlights (cont.)

- Several games and activity items purchased to add to existing activities and more emphasis will be given on choices of food to select
- Reminder to staff of everyone's responsibility to maintain clean and neat environment. Center also contacted janitorial company, reviewed daily cleaning schedule and underwent deep cleaning

How is CBAS Being Integrated into the Health Care Environment?

- CalOptima's Community Relations department provides education to the community regarding CBAS.
- CalOptima's Long-Term Services and Supports (LTSS) department provides regular trainings regarding CBAS to health networks, long-term care (LTC) facilities and other home- and community-based service providers.
- CBAS is being included in discharge planning via CalOptima and LTC facilities.

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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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
A Public Agency
CalOptima
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A Public Agency

CalOptima

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Hospice Overview

OneCare Connect Member Advisory Committee

October 27, 2016

Marsha Petersen, RN

Manager, Long-Term Services and Supports

Hospice Benefit for OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Members

- If a OneCare Connect (OCC) member elects the Medicare hospice benefit:
  - Enrollee may remain in the OCC program.
  - Enrollee will obtain the hospice services through the Medicare fee-for-service (FFS) benefit as a “carve out”
  - Medicare hospice services and hospice drugs and all other original Medicare services are paid for under the Medicare FFS.
  - OCC plan and the providers of hospice services would be required to coordinate these services with the rest of the enrollee’s care.
  - Election of hospice services does not change the Medi-Cal component.

Hospice Benefit for OCC Members (cont.)

- No Medi-Cal co-payments may be collected from Medi-Cal recipients who are receiving hospice services for any Medi-Cal services, including services that are not related to the terminal illness.
- Services by the attending physician and services that are not related to the terminal diagnosis should be billed in the usual manner by the physician performing the services.

Hospice Benefit for OCC Members (cont.)

- In the event a recipient who has elected hospice care seeks assistance at an emergency room or requests emergency transportation, the emergency service provider should obtain the name of the recipient's hospice and notify the hospice immediately. The hospice provider will take appropriate action.

Medi-Cal Core Services

- Core services within each level of care include:
  - Nursing services
  - Physical and occupational therapy
  - Speech-language pathology
  - Medical social services, home health aide and homemaker/ attendant services
  - Medical supplies and appliances
  - Drugs and biologicals
  - Physician services
  - Short-term inpatient care
  - Counseling

Services Not Covered

- When an individual is under the care of a hospice, separate payment will not be made, nor treatment authorizations approved, for the following when they are directly related to the terminal diagnosis:
  - Hospital
  - Nursing facility A or B
  - Home Health Agency care
  - Medical supplies and appliances
  - Drugs and biologicals
  - Durable medical equipment (DME)
  - Medical transportation
  - Any other services, as specified in California Code of Regulations (CCR), Title 22, related to the individual's terminal diagnosis

2016 Hospice Payment Process Changes

- This process does **not** include general inpatient.
  - CalOptima can no longer require authorization for hospice services at the following levels:
    - Routine home care
    - Continuous home care
    - Respite
  - CalOptima does require **notification** and **submission** of hospice medical records supporting the level of care the hospice has submitted claims for.
    - Claims have already been paid.
  - Long-term care nurse and medical authorization assistant (MAA) review the hospice medical records and validate the level of care the hospice submitted for payment.

Hospice Levels of Care

Level of Care	Notification	Validation
Routine Home Care	Notification Required within 30 calendar days of start of service.	Required for each certification period — two 90 calendar day periods, then unlimited 60 calendar day periods. Certification documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Notification Required within 30 calendar days of start of service.	Submit documentation to validate the member has received a minimum of eight hours of direct care within a 24-hour period.

Hospice Levels of Care (cont.)

Level of Care	Notification	Validation
Respite Care	Notification Required within 30 calendar days of start of service.	Submit documentation to validate that member received respite care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five consecutive days at a time.
General Inpatient Care	Authorization and Notification Required within one business day but no more than seven calendar days of start of service.	Required authorization will be granted in seven-day intervals upon validation of medical needs justification.

Special Physician Services

- Special physician services are those furnished by a physician hospice employee or a physician under arrangement with the hospice for managing symptoms that cannot be remedied by the patient's attending physician because of:
  - Immediate need or
  - The attending physician does not have the required special skills. (For example, a urologist assists the patient in voiding when the bladder is pathologically obstructed)

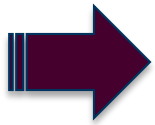
Hospice in Long-Term Care (LTC) Providers

Total Number of Providers REGISTERED	Total Number of Providers CONTRACTED
77	15

OCC Hospice Members Recorded in our Medical Records System

	FACILITY/PROVIDER	2015						2016								
		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
1	Companion Hospice				3		2			1					1	
2	Cadence HC LLC					1		1							2	
3	Evergreen Hospice Care	2	1	1	2	1						2	1	1	1	
4	Graceland Hospice Care									2		1			1	
5	Haven Health								1				2	1	1	
6	Heart to Heart Care, Inc.											2			1	
7	Heartland Home HC and Hospice			2		2										
8	High Quality Hospice						2			1		1		1		1
9	Hospice Touch, Inc.	1			2	3	1	1	2	6	3	5	5	5	4	1
10	Maxcare Hospice		2		1	1	1	5		1		1	3	2	1	
11	Optum Palliative and Hospice Care				1			1					1			

More facilities next slide



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OCC Hospice Members Recorded in our Medical Records System (cont.)

	FACILITY/PROVIDER	2015						2016								
		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
12	PEC HC and Hospice		1													
13	Rhodes Care Hospital							2		1					1	
14	Sanctuary Hospice	1			1					2		2	2	1	2	
15	Sonoran Winds Hospice, Inc.						1	2	1	1			1	1	1	
16	St. Joseph Health System Home Care Services		1										1		1	
17	St. Michael Hospice									1	1		1	1		
18	VNA of OC	1		1												
19	Vesper Hospice									2						
20	Vitas HC Corp. of CA Orange	1	1	2	1	2	2	5	4	2	3	3	3	4	4	2
	TOTAL Hospice Cases / Month	6	6	6	11	8	9	17	8	20	7	17	20	17	22	4
	Total OCC Hospice Members Recorded in our Medical Records System (Jul 2015 –Sep 2016)	178														

Approval and Denial Rate for Hospice in LTC

REASONS For Approval and Denial	DENIAL RATE	APPROVAL RATE
Bed availability for OCC hospice members	0%	100%
Other reasons for not taking OCC hospice members	0%	100%

CalOptima Poll of Hospice Providers

- The LTC team polled a minimum of five of our contracted hospice providers.
- Our questions were “Are you taking our OCC members and providing hospice services” and “are you having any problems with the long-term care nursing facilities taking the OCC members while they are under your hospice services?”
  - St Michael Hospice
  - Vitas Hospice
  - Hospice Touch
  - VNA
  - Companion Hospice

CalOptima Poll of Hospice Providers (cont.)

- Response: 100% stated they have had no problems finding a bed for OCC members for hospice services and they take all members who need their hospice services no matter what program they are in.

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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November 2016 Ballot Initiatives:
Overview of Propositions 52, 56 and 61

CalOptima OneCare Connect Member Advisory Committee (OCC MAC) Meeting
October 27, 2016

On November 8, 2016, California voters will consider several ballot initiatives. Ballot initiatives are part of our state's "direct democracy" system of governance, which offers voters the option to directly effectuate statutory or constitutional change without the support of the Legislature or the governor. Three of these ballot measures, Propositions 52, 56 and 60, if enacted, will have a significant impact on the Medi-Cal program. For informational purposes only, the following analysis summarizes the propositions and their effect on CalOptima.

Proposition 52 (Hospital Quality Assurance Fee)

Proposition 52, sponsored by the California Hospital Association (CHA), would permanently extend the Hospital Quality Assurance Fee (QAF) and make it harder for the Legislature to change how fee revenue is collected and disbursed. The Hospital QAF program was originally established by Assembly Bill (AB) 1383, enacted in 2009. The fee has subsequently been renewed by the Legislature multiple times and California's Fiscal Year (FY) 2016–17 budget extends the sunset date of the current QAF to January 1, 2018.

Background

The Hospital QAF is designed to reimburse private hospitals for the uncompensated cost of providing care to Medi-Cal beneficiaries and the uninsured. California's acute care hospitals often provide services to individuals who cannot pay, specifically the uninsured population or Medi-Cal beneficiaries. Though hospitals receive reimbursement for care provided to Medi-Cal beneficiaries through managed care plans or via fee-for-service payments, this is often not enough to cover the cost of care. In an effort to address this issue, CHA worked with the Department of Health Care Services (DHCS) to structure a fee that private hospitals would pay to the state, which would in turn help the state maximize the federal Medicaid matching dollars coming to California. The state would then disburse the aggregate amount to hospitals in order to help compensate them for costs of providing care for the uninsured and Medi-Cal populations. This effort produced the first Hospital QAF in 2009 and has since brought billions of dollars to the state's hospitals for uncompensated care.

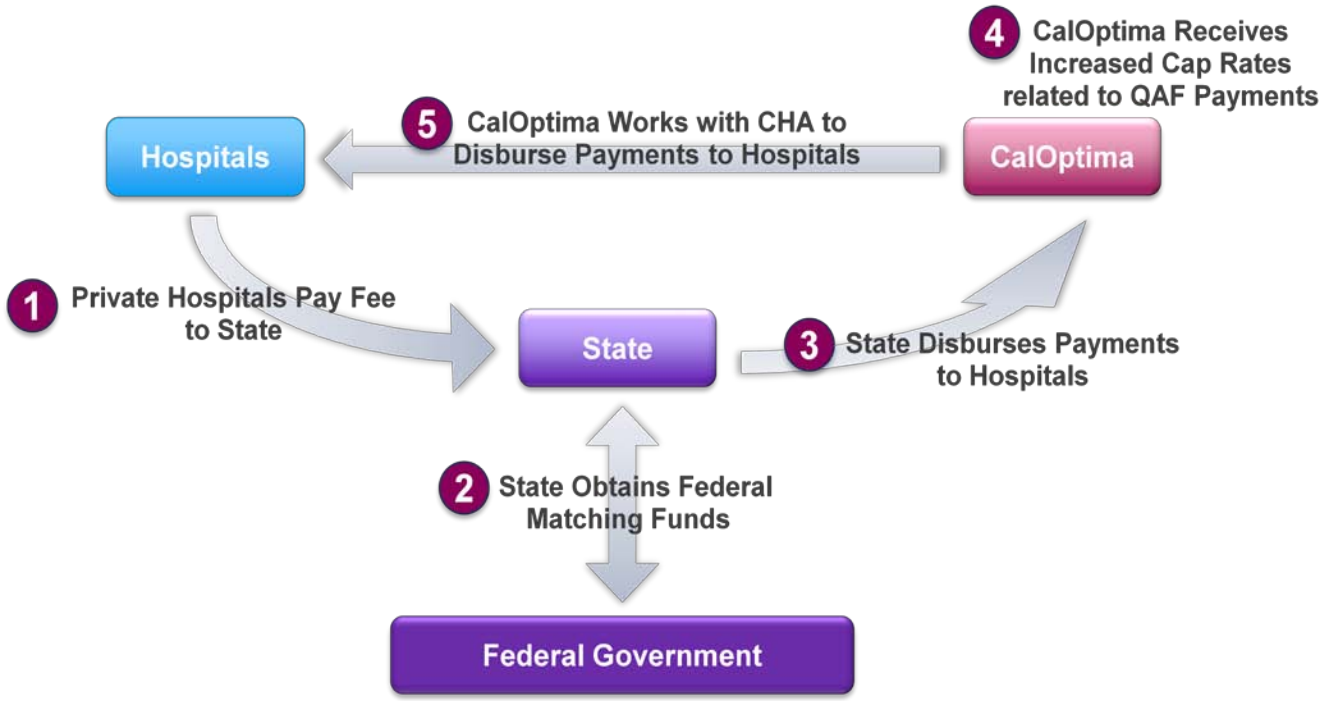
Hospital QAF Structure

First, hospitals agree to pay a fee to the state. Under the current iteration of the Hospital QAF, this fee is based on each hospital's number of inpatient days and is assessed on a quarterly basis. The amount of the fee per inpatient day varies depending on payer type. Hospitals pay the highest rate for Medi-Cal inpatient days and lower rates for days paid for by other payers, such as private insurance. The fee is structured in this manner in order to comply with the provisions of federal Medicaid law, which require that health care-related taxes must be broadly applicable, and to reduce the tax burden on those hospitals that see a smaller proportion of Medi-Cal and uninsured patients (these hospitals also see a much smaller QAF return as well).

Second, the state designates the majority of the proceeds from the Hospital QAF for Medi-Cal spending, thus, making that portion of fee revenue eligible for federal matching funds. The state keeps a defined amount of the fee for administrative costs and uses a percentage of the fee revenue to generate state budget savings (by offsetting a portion of the General Fund (GF) spending designated for providing children's health care). The remaining amount of the state's fee revenue, since it is earmarked for Medi-Cal, is eligible for federal matching funds.

Third, after the federal government provides matching funds, the state disburses the aggregate amount, less the state's portion to cover administrative costs and the GF offset, to hospitals through payment increases. These disbursements are known collectively as quality assurance payments, and they take the following three forms: 1) Increased capitation payments to Medi-Cal managed care plans, which pass through the payments to hospitals, 2) Supplemental payments to private hospitals, and 3) Direct grants to public hospitals. The diagram below illustrates this process.

The Hospital QAF Process: Orange County Impact



Health plans are required to "pass through" the entire amount of the QAF-related capitation increase to hospitals. CalOptima works with CHA to determine the amounts that should be disbursed to each of these hospitals. Currently, there are 24 hospitals in Orange County receiving QAF-related payments from CalOptima and the most recent disbursement to these hospitals totaled more than $40 million.

Impact of the Proposition, if Enacted

In 2012, while the state was dealing with an economic downturn and a related budget crisis, the Legislature diverted some QAF revenue to the GF. This, combined with the 10 percent Medi-Cal

rate reduction enacted by AB 97 in 2011, exacerbated hospitals' financial difficulties during the recession. CHA hopes to offer hospitals greater protection from future budget uncertainties by making the Hospital QAF permanent through Proposition 52. The measure would remove the fee's sunset date and make the program as well as all its statutory provisions — including the formula that limits how much QAF revenue can be used for GF offsets — permanent.

Since the fee generates federal matching funds for Medi-Cal, the changes effectuated by Proposition 52 would have to be approved by the federal government in the event that the measure passes. The state's Legislative Analyst's Office (LAO) estimates that in securing the future of the Hospital QAF, Proposition 52 would generate annual GF savings of approximately $1 billion. Also, according to the LAO, hospitals received a net benefit — the amount they received from the state, including the federal match, less the amount that they paid to the state in QAF — of $3.5 billion in FY 15–16.

Proposition 56 (Tobacco Tax)

Proposition 56 is sponsored by the American Cancer Society Cancer Action Network, American Lung Association of California and the American Heart Association. The measure would increase the state excise tax on cigarettes by $2 per pack, from 87 cents to $2.87, on April 1, 2017. Tobacco products are subject to both state and federal excise taxes as well as state and local sales and use taxes. California currently has one of the lowest cigarette excise taxes in the country.

Background

Under current California law, the excise tax on cigarettes also applies to other tobacco products, such as chewing tobacco and cigars. Electronic cigarettes, also known as E-cigarettes, are currently exempt. Proposition 56 would raise the excise tax and extend its application to E-cigarettes. Proponents of the measure state that, in addition to raising revenue for state-funded health care programs, increasing the tobacco excise tax would drive down demand for tobacco products, decrease overall health costs and improve health outcomes for individuals.

Tobacco excise taxes are paid by distributors who supply tobacco products to retailers. Typically, retailers will pass on the cost of the excise tax to consumers in the form of higher prices on cigarettes and other tobacco products. It is likely that higher prices, in turn, will drive down demand for tobacco products, leading to diminishing state revenues from tobacco-related taxes. This is important to note, as the LAO estimates that Proposition 56 could generate a significant decrease in state revenue.

Impact of the Proposition, if Enacted

California's existing tobacco excise tax generated approximately $840 million in FY 14–15. Revenues from the existing cigarette tax are allocated according to two previous Propositions, 10 and 99, which designate the funds for tobacco education and prevention efforts, among other health-related expenditures. The LAO estimates that Proposition 56's expansion of the tobacco excise tax would generate $1 billion to $1.4 billion in revenue in FY 17–18, the first full year of implementation. Proposition 56 revenues would be deposited in a new special fund, which would not be subject to appropriation by the Legislature. This would ensure that Proposition 56 funding would be used only for the purposes described in the initiative. The revenue generated by the

measure would be designated first for certain administrative costs that state and local governments would incur related to implementing the tax. It would also distribute predetermined amounts of funding for specified state projects, such as $40 million to the University of California for physician training and $6 million to the Office of the Attorney General to enforce tobacco laws.

Medi-Cal Impact

According to the proposition, 82 percent of the remaining revenue would be allocated to DHCS to increase the level of payment to Medi-Cal providers for health care services provided to Medi-Cal beneficiaries. According to the measure's terms, this new source of funding would be used to supplement the existing Medi-Cal budget, rather than offset current GF spending. [1] This could potentially lead to an increase in the rates that Medi-Cal providers, including managed care plans, receive from DHCS for providing care to beneficiaries. LAO estimates that Medi-Cal will receive $710 million to $1 billion in Proposition 56 funding in FY 17–18 if the measure passes.

However, as noted above, revenue related to this measure may decline in the future as higher prices for tobacco products influence a decrease in demand for tobacco products. It should also be noted that the Legislature passed numerous tobacco-related bills this year that may subsequently impact the demand for tobacco products, including Senate Bill (SB) 1400, which, among other regulatory changes, raises the minimum age for purchasing tobacco products from 18 to 21 beginning January 1, 2019.

Proposition 61 (Drug Pricing Standards)

Currently, state agencies purchase pharmaceuticals in many different ways. In some circumstances, the state is empowered to purchase drugs directly from manufacturers. In others, the state reimburses retail pharmacies for the cost of prescription drugs dispensed to beneficiaries of certain state programs. Frequently, the state does not pay a single amount for a specific drug, with cost varying by program, since different payers negotiate different prices with various drug manufacturers. In FY 14–15, state drug expenditures totaled $3.8 billion, approximately half of which was paid through state prescription drug spending and the rest by federal and other non-state sources.

Proposition 61 is sponsored by the AIDS Healthcare Foundation. The measure would limit the amount that state agencies, with specified exceptions, can pay for a drug to the lowest price paid by the U.S. Department of Veterans Affairs for the same drug. This requirement would apply regardless of how the state pays for the pharmaceuticals in question, whether as a direct purchaser or through reimbursements to pharmacies. Proponents posit that the measure could save the state more than $5 billion over 10 years. The LAO, however, offers a more tentative assessment of the measure's fiscal impact, stating that the amount of state savings is uncertain and would depend on how the measure is implemented as well as the responses of pharmaceutical companies regarding the pricing and provision of their drugs. Proposition 61 coincides with legislative efforts, such as SB 1010 and AB 463, both of which were unsuccessful, to address the rising costs of prescription drugs.

[1] Legislative Analyst's Office. November 30, 2015. Review of Proposed Constitutional and Statutory Initiative (A.G. File No. 15-0081, Amendment #1). Retrieved from http://www.lao.ca.gov/ballot/2015/150544.pdf.

This measure would not directly impact CalOptima, as Medi-Cal managed care plans are explicitly exempted from the measure's provisions. Proposition 62's changes would apply only to the Medi-Cal fee-for-service program. However, since many CalOptima members access various Medi-Cal fee-for-service programs, including Denti-Cal and county mental health services, there could be downstream impacts.

Next Steps

CalOptima will closely follow the status of these propositions and provide an update following the November 8 election.

About CalOptima

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

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

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OneCare Connect

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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Enrollment Update

October 27, 2016

Belinda Abeyta, Director, Customer Service

Enrollment by Health Network

Health Network	Total Membership
Monarch	5,552
Prospect Medical Group	3,323
Family Choice Medical Group	1,958
CalOptima Community Network	1,933
Talbert	1,256
UCMG	693
ARTA	657
AMVI Care	647
Alta Med	577
Noble	483
Heritage – Regal	175
OC Advantage	122
Heritage – ADOC	60
Total	***17,436***

Source: CORE Report CS0020 Pulled 10/17/2016

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Enrollment as of 10/17/2016

Month	End of Prior Month Enrollment	Voluntary Enrollment	Reinstated/Re-Enrolled Enrollment	Beginning of Month Members	Disenrollment - Involuntary	Disenrollment - Voluntary	Ending Enrollment
August 2016	18,135	95	29	18,259	260	404	17, 595
September 2016	17,595	124	27	17,746	207	283	17,256
October 2016	17,256	144	36	17,436			

Source: CORE Report OC0111A Pulled 10/17/2016

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OCC Deeming

Month	Members in a Deeming Status	Regained OCC Eligibility at the end of Deeming	Termed OCC at the end of Deeming	Regained Medi-Cal Eligibility 1 Month After Termed OCC	Regained Medi-Cal Eligibility 2 Months After termed OCC	Has not regained Medi-Cal Eligibility after termed OCC
August 2016	207	55	152	22	18	112
September 2016	181	49	132	20	0	112
October 2016	215					

Source: CORE Report OC0109 Pulled 10/17/2016


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OneCare Connect

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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Program Update

OCC Member Advisory Committee

October 27, 2016

Candice Gomez

Executive Director, Program Implementation

New Benefits – Effective 7/1/2016

- Acupuncture
  - Limit of two visits per calendar month
  - Two-visit limit may be exceeded for medical necessity
    - Authorization rules may apply

- Continuity of Care
  - Continuity of care for Medi-Cal services increased from six to 12 months

New Benefits – Effective 1/1/2017

- Fitness benefit options
  - Health club membership
  - Fitness classes
  - Home fitness kits
    - Includes wheelchair and bed-bound programs

- Transportation
  - Taxi benefit increased from 30 to 60 one-way rides

Member Notifications

Date	Notification
September	➢ Annual Notice of Change (ANOC) ➢ Summary of Benefits ➢ 2017 member materials posted to CalOptima website
October	➢ Newsletter (with news about acupuncture and continuity of care provisions)
December	➢ Member Handbook/Evidence of Coverage ➢ Provider directory information

Marketing

- Direct mail to newly eligible members
- Transit Advertisements
  - English, Spanish, Vietnamese and Korean
- Print Advertisements
  - English, Spanish and Vietnamese
- Radio Campaigns
  - English and Spanish

Transit Shelter Ad

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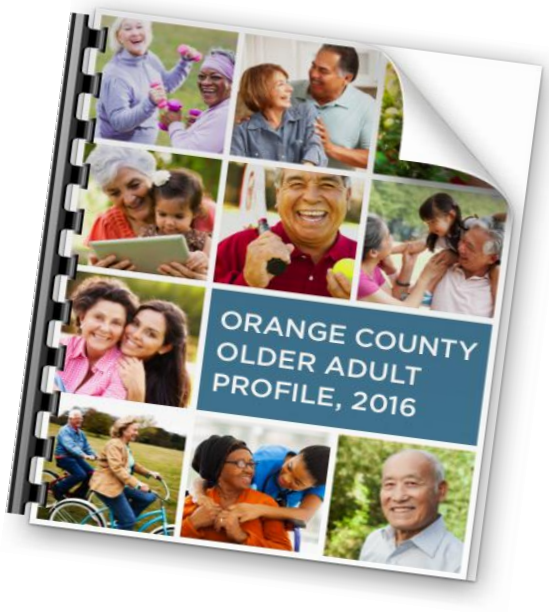
Older Adult Profile 2016
&
OC Strategic Plan for aging

Christine Chow – Alzheimer's Orange County
Erin Ulibarri – Orange County Office on Aging

Older adult profile 2016

- Provides an overview of the health and wellbeing of the older adult population in Orange County
- Highlights key health, social, and economic indicators
- Effort led by Health Care Agency in collaboration with OC Healthy Aging Initiative
- Detailed data found on

  OC Healthier Together website



Key Findings

- By 2040, almost 1 in 4 residents will be 65 or older.
- Using the Elder Economic Security Index (EESI), 21.9% of couples and 44.2% of singles do not have sufficient income for basic needs.
- The physician workforce specializing in geriatrics is less than 25% of the recommended number.
- In contrast to decreasing chronic disease death rates, death due to Alzheimer's disease has been increasing - now the third leading cause of death in older adults.
- 31.1% of elder abuse was financial abuse, and almost two-thirds of alleged abusers were family members.

HTTP://WWW.OCHEALTHIERTOGETHER.ORG

County: Orange

Wellness & Mortality

	VALUE	COMPARED TO:			
		population)			

Chronic Health Conditions

	VALUE	COMPARED TO:			
Arthritis Prevalence: 65+	32.4% (2014)	CA Counties	U.S. Counties	CA Value (28.8%)	Prior Value (32.5%)
Asthma Prevalence: 65+	5.4% (2014)	CA Counties	U.S. Counties	CA Value (4.9%)	Prior Value (5.5%)
Diabetes Prevalence: 65+	26.5% (2014)	CA Counties	U.S. Counties	CA Value (26.0%)	Prior Value (26.9%)
Hypertension Prevalence: 65+	55.9% (2014)	CA Counties	U.S. Counties	CA Value (53.1%)	Prior Value (56.8%)
Ischemic Heart Disease Prevalence: 65+	27.7% (2014)	CA Counties	U.S. Counties	CA Value (26.2%)	Prior Value (28.8%)
Osteoporosis Prevalence: 65+	9.8% (2014)	CA Counties	U.S. Counties	CA Value (7.6%)	Prior Value (9.9%)
Stroke Prevalence: 65+	4.0% (2014)	CA Counties	U.S. Counties	CA Value (3.7%)	Prior Value (4.0%)
Hospitalization Rate due to Congestive Heart Failure: Adults 65+	95.6 Hospitalizations per 10,000 population 65+ years (2011-2013)	CA Counties	CA Value (111.5 hospitalizations/ 10,000 population 65+ years)	Prior Value (100.8 hospitalizations/ 10,000 population 65+ years)	

People 65+ Living Alone

County: Orange

This indicator shows the percentage of people aged 65 years and over who live alone.

Why is this important?

People over age 65 who live alone may be at risk for social isolation, limited access to support, or inadequate assistance in emergency situations. Older adults who do not live alone are most likely to live with a spouse, but they may also live with a child or other relative, a non-relative, or in group quarters. The Commonwealth Fund Commission on the Elderly Living Alone indicated that one third of older Americans live alone, and that one quarter of those living alone live in poverty and report poor health. Rates of living alone are typically higher in urban areas and among women. Older people living alone may lack social support, and are at high risk for institutionalization or losing their independent life style. Living alone should not be equated with being lonely or isolated, but many older people who live alone are vulnerable due to social isolation, poverty, disabilities, lack of access to care, or inadequate housing.

Less

County: Orange

VALUE

22.0%

Source: American Community Survey
Measurement period: 2010-2014
Maintained by: Healthy Communities Institute
Last update: January 2016

COMPARED TO

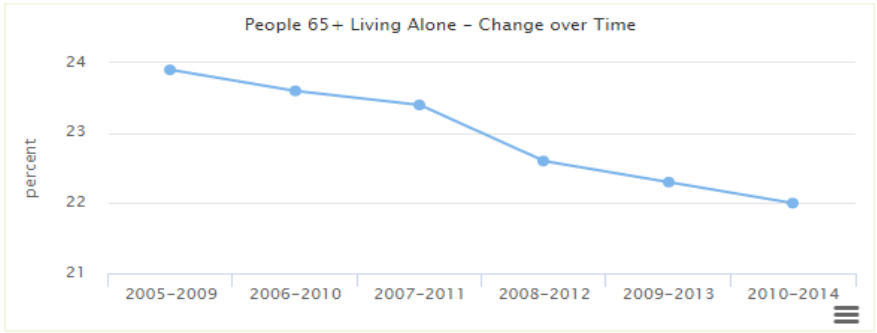
CA Counties | U.S. Counties | CA Value (23.6%) | US Value (26.8%)

Prior Value (22.3%)

Graph Selections

INDICATOR VALUES

Change over Time



COUNTY | ZIP CODES | CENSUS TRACTS

SELECT A COMPARISON

Ranked | CA Counties | U.S. Counties | CA State Value | U.S. Value | Prior Value

OC Strategic Plan for aging

Purpose: to develop a Strategic Plan to prepare Orange County for the growing numbers of seniors and the issues they face.

Strategy: to base the OCSPA on qualified data and assessments on the state of Seniors – focused on where they are the most vulnerable and in need, with concrete steps to address those needs over time.

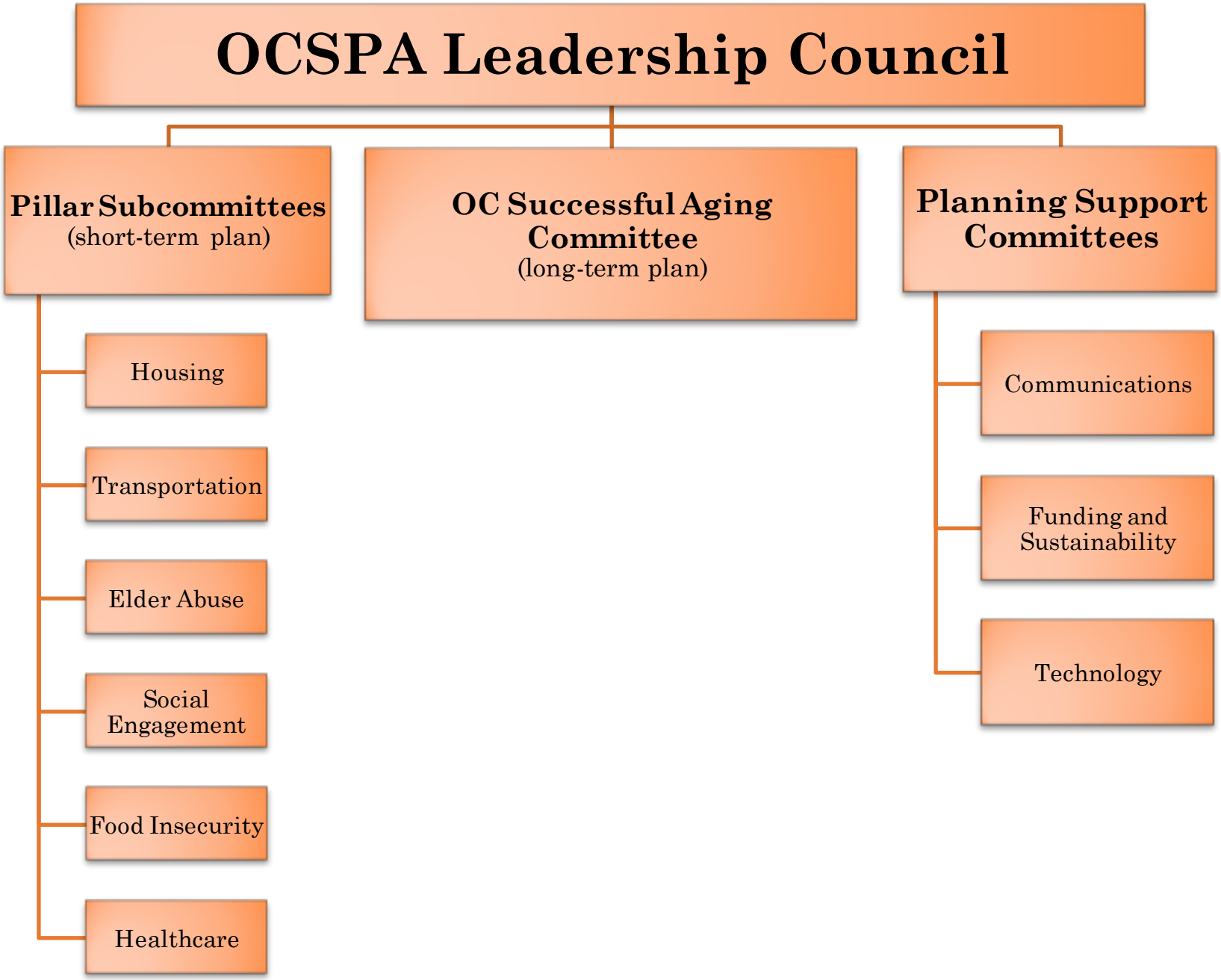
OCSPA Concept Launch-
October 2015 Funders' Forum on Aging

Leadership Council Members

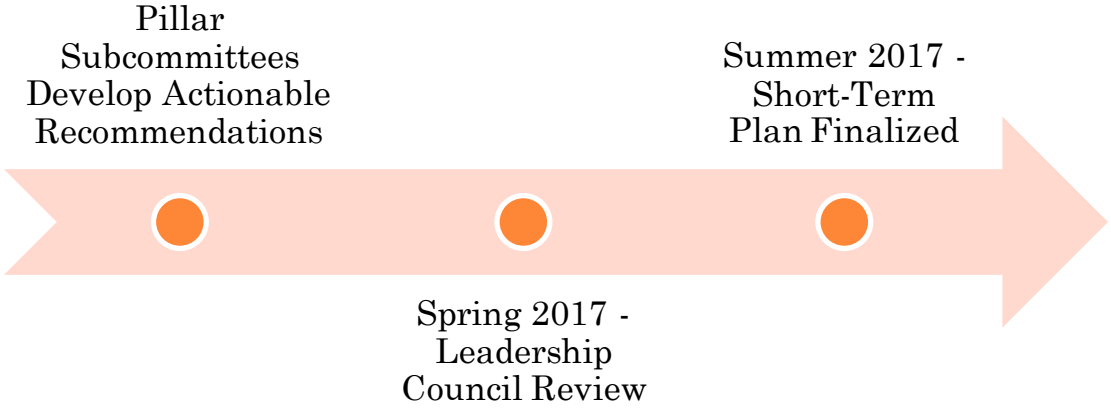
- County of Orange
  - Office on Aging
  - Chairwoman Lisa Bartlett
  - Health Care Agency
  - OC Transportation Authority
- Age Well Senior Services
- Alzheimer's Orange County
- CalOptima
- Council on Aging OC
- Hoag Community Benefit
- Integrity Housing
- Irvine Health Foundation
- Jamboree Housing
- OC Community Foundation
- OC United Way
- SeniorServ

Structure

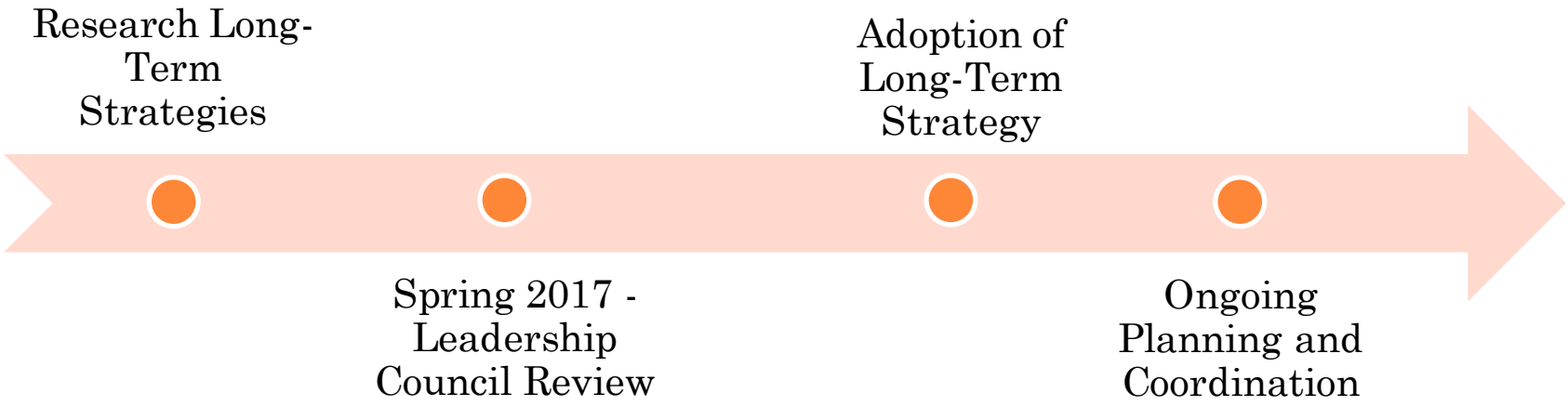
- Adopt at least three “pillars” around known needs for seniors to achieve near-term (18 month) wins that will provide measurable, county-wide impact.
- In parallel, consider longer term strategies for strategic planning.
- Develop focused efforts in the areas of funding, technology, and communications in support of all planning efforts.
- Invite cities to participate in planning efforts.


OCSPA Leadership Council
Pillar Subcommittees
(short-term plan)
OC Successful Aging Committee
(long-term plan)
Planning Support Committees
Housing
Transportation
Elder Abuse
Social Engagement
Food Insecurity
Healthcare
Communications
Funding and Sustainability
Technology

Short-Term Planning



Long-Term Planning



Potential Long-Term Planning Models/tools

Best Cities for Successful Aging

Los Angeles Purposeful Aging — An Age-Friendly Initiative

The AdvantAge Initiative

AARP Livable Communities — Great Places for All Ages℠

Community AGEnda

Stanford Center on Longevity

MetLife Mature Market Institute

Next steps

Short Term

- March 2017 - Leadership Council to review short-term plan recommendations and initial research for longer-term planning efforts.
- Summer 2017 – Short-term plan finalized and implementation started.

Long Term

- Elevate the dialogue around aging – county, city, funders, non-profits, etc.
- Create a longer-term strategy that better utilizes private and public funding alongside local resources.