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

THURSDAY, FEBRUARY 9, 2017
8:00 A.M.

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

AGENDA

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

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

I. CALL TO ORDER
Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES
A. Approve Minutes of the December 8, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC)

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

V. REPORTS
None

VI. CEO AND MANAGEMENT REPORTS
A. Chief Operating Officer (COO) Update
B. Chief Financial Officer (CFO) Update
C. Chief Medical Officer (CMO) Update

VII. INFORMATION ITEMS
A. Federal and State Legislative Update
B. Magellan Healthcare Update
C. Pay for Value Update
D. Whole Person Care Pilot
E. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

MINUTES

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

December 8, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 8, 2016, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:07 a.m., and Barry Ross led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Stephen N. Flood; Teri Miranti; John Nishimoto, O.D.; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Suzanne Richards, RN, MBA, FACHE; Barry Ross, R.N., MPH, MBA; Jacob Sweidan, M.D.
Members Absent:	Alan Edwards, M.D.; Jena Jensen; Pamela Kahn, R.N.; George Orras, Ph.D., FAAP
Others Present:	Michael Schrader, Chief Executive Officer; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Chet Uma, Chief Financial Officer; Gary Crockett, Chief Counsel; Candice Gomez, Executive Director, Program Implementation; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the November 10, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Ross, seconded and carried, the Committee approved the minutes of the November 10, 2016 meeting. (Motion carried 11-0-0; Members Edwards, Jensen, Kahn and Orras absent)***

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, updated the PAC on CalOptima Board of Directors actions from the December 1, 2016 Board Meeting. Mr. Schrader noted two areas of potential change: Medicaid Expansion and the federal funding mechanism for Medicaid. Potential changes to Medicaid Expansion (Expansion) could end or severely limit funding for the Cal MediConnect (CMC)/OneCare Connect (OCC) Program. With regard to federal funding to states for Medicaid, the funding mechanism could shift from the current Federal Medicaid Assistance Percentage to block grants or a per capita system. He also noted that any potential changes are speculative, but that he will be monitoring developments and working with our partners at the local, state and federal levels.

A lenghty discussion among the PAC members ensued about alternatives available that the state could pursue. Mr. Schrader noted that he and several CEOs of the 11 Plans participating in CMC met with the Secretary of Health and Human Services, Diane Dooley, and the Director of the California Department of Health Care Services, Jennifer Kent. The Plans are preparing for an upcoming meeting with the California Department of Finance (DOF) in an effort to show the DOF that the newer CMC program is starting to show savings. Mr. Schrader will update the PAC members when more information becomes available.

Chief Financial Officer Update

Chet Uma, Chief Financial Officer, presented CalOptima's Financial Report for October 2016, including a review of the Health Network Enrollment Summary for the month of October 2016.

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer provided an update on CalOptima's Program of All-Inclusive Care for the Elderly (PACE). Dr. Helmer reported that staff has continued to work with the transportation vendor to address timeliness issues. Dr. Helmer discussed the proposed Alternative Care Setting (ACS) model and noted that plans to move forward with ACS would be dependent on the PACE Center meeting financial performance targets.

Dr. Helmer reported that the CalOptima Community Network (CCN) is now the fourth largest network for OneCare Connect and discussed plans for assuring quality.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, noted that the CCN reached the 10% membership threshold. She noted that auto assignment would cease after three months if membership remains at 10%. Ms. Khamseh reiterated that members could actively select the CCN even after auto assignment has stopped.

Ms. Khamseh also noted that at the December 1, 2016 Board Meeting, the Board extended the deadline to December 31, 2017 for qualifying existing Health Networks that elected to change their contracting models to complete readiness assessment requirements.

Ms. Khamseh reported that members have received notification that they may have to choose a different behavioral health provider if Magellan Healthcare (Magellan) does not contract with their current behavioral health provider. Magellan is currently in the process of contracting with additional behavioral health providers before the transition occurs on January 1, 2017.

INFORMATION ITEMS

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a State and Federal legislative update regarding the November 2016 election results and changes to the Orange County legislative delegation.

Whole Child Model

Candice Gomez, Executive Director, Program Implementation presented an update on the Whole Child Model. This program, also known as the California Children's Services (CCS), is a statewide program providing medical care, case management, physical therapy and occupational therapy as well as financial assistance for children meeting eligibility criteria, up to age 21. Currently, the Orange County Health Care Agency (OCHA) is responsible for CCS services for approximately 12,000 children. Services provided under this Program are carved out of most Medi-Cal managed care programs. The CCS Program is scheduled to transfer to CalOptima beginning January 1, 2018; however, this transfer could be delayed an additional six months.

In addition, CalOptima plans to hold external stakeholder meetings to share information on this Program and recruit for two proposed CalOptima advisory committees. A Family Advisory Committee would consist of CCS families, and one representative on this Committee would serve on the State Advisory Committee. The Clinical Advisory Committee would consist of the current Orange County CCS Medical Director, four CCS-paneled providers, and would be led by CalOptima's Chief Medical Officer.

PAC Member Comments

Chair Miranti requested volunteers to serve on the 2017/18 PAC Goals and Objectives Ad Hoc Subcommittee. Members Nishimoto, Richards and Ross agreed to serve on the Ad Hoc with Chair Miranti.

Chair Miranti reminded the Committee that the PAC would not meet in January 2017. The next PAC meeting is scheduled for February 9, 2017.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:41 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: February 9, 2017

MEMORANDUM

DATE:	February 2, 2017
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

Chairman Retirement

CalOptima Board of Directors Chairman Mark Refowitz announced his retirement as director of the Orange County Health Care Agency, effective March 30, 2017. CalOptima is indebted to Chairman Refowitz for his steady and strong leadership since 2012. Together with CalOptima staff, I wish him all the best in his next chapter, and yet we will certainly miss him. He provided excellent guidance across five years of notable events for the agency, including the expansion of Medi-Cal, the launches of the Program of All-Inclusive Care for the Elderly (PACE) and OneCare Connect, and the recognition of CalOptima as the top quality Medi-Cal plan in California. Succession arrangements are pending.

Proposed Fiscal Year 2017–18 State Budget

On January 10, Gov. Brown released his proposed Fiscal Year 2017–18 state budget. Medi-Cal enrollment is projected to reach 14.3 million. This figure is flat compared with the current year and does not make any assumptions about possible federal Medicaid changes. Apart from the enrollment projection, the most significant news for CalOptima is the extension until December 31, 2019, of Cal MediConnect (CMC), known as OneCare Connect in Orange County. Consistent advocacy by CMC health plans helped spare the program, even while the governor proposed to eliminate the Coordinated Care Initiative (CCI) that originally authorized CMC. Based on the Department of Finance's assessment that CCI was not cost-effective, the initiative is slated to end January 1, 2018, along with the changes that CCI made to the In-Home Supportive Services (IHSS) program. Under the proposed budget, the state will return responsibility for IHSS collective bargaining to CMC counties, and IHSS benefits will be removed from health plan capitation rates. Given that the proposed budget will now be considered by the Legislature for the May Revise, CalOptima will continue our advocacy to ensure the positive outcome of OneCare Connect's extension is upheld. And over the next few months, the County of Orange will examine the complex transition of the IHSS program, which may have significant financial implications. In the past year, IHSS costs have increased based on higher wages and more benefits for IHSS workers. The County reports that approximately 29,000 Orange County residents are enrolled in the IHSS program. IHSS is a Medi-Cal benefit considered an alternative to nursing home care. My attendance at the January 18 California Association of Health Plans (CAHP) Meeting in Sacramento provided valuable information about the budget provisions and CAHP's response. Attendees were generally pleased about the opportunity to continue CMC, given the promise it shows to lower costs and better coordinate

care. The group also had a lengthy discussion about the disposition of the IHSS program and its challenge of rising costs. CalOptima will stay engaged with CAHP as well as Local Health Plans of California (LHPC) as the state budget moves toward a final version. Of note, LHPC has planned a legislative briefing on February 14 in Sacramento. I will be a speaker at the event, discussing CMC and CCI.

Affordable Care Act (ACA)

Given that 30 percent of our members may be affected, CalOptima is tracking closely potential changes to the ACA provisions involving Medicaid expansion. After the presidential inauguration, Congress started the budget reconciliation process with a blueprint that instructs four congressional committees to develop ACA repeal language for the budget, which could be used to reduce or eliminate funding for Medicaid expansion. In the meantime, President Trump signed an Executive Order directing federal agencies to minimize the economic and regulatory burdens of the ACA and give greater flexibility to the states. In this rapidly changing environment, CalOptima is taking action by conferring regularly with colleagues from other health plans and actively participating in our association meetings, including two recent events with Medicaid Health Plans of America (MHPA) and Local Health Plans of California (LHPC).

- **MHPA Meeting:** The MHPA meeting January 10–11 in Washington, D.C., focused on what may happen with Medicaid and the ACA under President Trump. Discussion centered on the possible movement from Medicaid's current Federal Medical Assistance Percentage (FMAP) payment methodology to other payment models, such as block grants. Presently under FMAP, there are wide variations between states, and California is among the states with the lowest FMAP nationwide. MHPA officials also emphasized that the association and member plans should position themselves as trusted resources in the effort to shape future Medicaid changes.
- **LHPC Strategic Planning Meeting:** On January 24–25, I participated in the LHPC session to set strategic priorities for the association. This included meeting the association's new federal lobbyists, John Russell and Jenifer Healy of Dentons, and strategizing on the risks and opportunities ahead for local health plans.

These events offered helpful preparation for CalOptima's participation in the Association for Community Affiliated Plans (ACAP) Washington, D.C., fly-in February 7–8. Public Medi-Cal managed care plans, including CalOptima, will meet with the four congressional committees working on ACA issues as well as their own elected delegations. Our priority will be to advocate for the best possible outcome for Orange County. While I am in Washington, I have also scheduled a meeting with Centers for Medicare & Medicaid officials about OneCare Connect. In all, this time in the capital will provide a valuable indication about the future of our Medi-Cal expansion and other programs. I will share an update with your Board upon my return.

Health Network CEO Meeting

CalOptima hosted a well-attended health network CEO meeting on January 12, and several CEOs expressed appreciation for the opportunity to participate in these quarterly events. The CEOs were particularly interested in the pay-for-value update, whereby Executive Director of Quality and Analytics Caryn Ireland reviewed the variety of incentive programs available for health networks to boost revenue based on making quality improvements. Executive Director of Compliance Silver Ho also shared a comparison of compliance performance across all health

networks, and I provided brief remarks about the proposed FY 2017–18 state budget and revised California Children's Services timeline. Leaders asked CalOptima to provide data comparing Community Network and the private-sector networks, and our plan is to share information about areas such as utilization management, quality and expenses at the next CEO meeting.

Behavioral Health Transition
The January 1 behavioral health transition to Magellan Healthcare was executed with very little disruption to members. Magellan's broad network includes more than 500 contracted vendors, so that 95 percent of members receiving either Medi-Cal-covered behavioral health services or autism treatment services had access to the same providers they used prior to the transition. The majority of the continuity of care requests CalOptima received have already been resolved due to Magellan's contracting efforts. During January, CalOptima and Magellan held daily huddles to discuss call center metrics and other issues. In all, thorough planning and effective collaboration paved the way for a successful start to our new partnership with Magellan, which is aimed at improving behavioral health services.

Regulatory Audits
Starting next week, CalOptima will participate in major yet routine regulatory audits by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). Up to 20 auditors from both agencies will be on-site. From February 6–17, DHCS will evaluate Medi-Cal's compliance with our contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. From February 6–10, DMHC will be reviewing Medi-Cal's compliance with the Seniors and Persons with Disabilities (SPD) 1115 Waiver and OneCare Connect's provision of Medicaid-based services. DMHC will conduct these audits on behalf DHCS as part of an interagency agreement. For both the Medi-Cal SPD Waiver and OneCare Connect Medicaid services, the audit will evaluate compliance with our contract and regulations in the areas of utilization management, continuity of care, availability and accessibility of services, member rights, and quality management. To prepare for the audits, CalOptima hosted a workshop in January to educate our delegated health networks and share resources for audit readiness.

Interim Chief Financial Officer
Effective January 17, CalOptima Controller Nancy Huang was appointed Interim Chief Financial Officer. She has been with CalOptima for nearly nine years, first for six years as a financial analyst from 2005–11, and more recently, as controller from April 2014 to present. Nancy has financial management experience on the provider side as well, having worked for a large mental health provider for several years. Nancy holds a bachelor's degree and an MBA from Cal State Fullerton.

California Children's Services (CCS) Transition Delay
In January, the CCS Advisory Group met for an update about the transition to the Whole-Child Model, which moves CCS services into managed care. Based on DHCS' heavy workload on programs stemming from the new federal Medicaid regulations, known as the Mega Reg, DHCS

announced a delay in the implementation date for integrating CCS into CalOptima. The transition in Orange County will now occur no sooner than January 2019.

Hospital Quality Assurance Fee (QAF)
In late January, CalOptima passed through $72.4 million to 24 Orange County hospitals as part of the DHCS QAF program that provides supplemental payments to hospitals through managed care plans. DHCS determined the amount of the payments, which cover the period of July–September 2014. CalOptima transmitted the payments ahead of the required 30-day timeframe.

Intergovernmental Transfer Payment
In December, CalOptima received partial payment for the Intergovernmental Transfer Program for Rate Year 2014–15 (IGT 5). The payment erroneously omitted capitation for July 1, 2014–September 30, 2014. IGT 5 funding partners (or their designated providers) received a prorata share payment based on their plan/provider agreement and the amount received from DHCS at that time. In January, CalOptima received a second payment for the missing period, and a second payment to our funding partners or their designated providers was processed. We do not expect to receive further IGT 5 payments from DHCS. CalOptima's net benefit from the transaction is $14.4 million. In December, your Board approved the use of these funds for community grants, which will be awarded based on the results of an upcoming member health needs assessment.

Rate Adjustment for OneCare Connect Members in Nursing Homes
In 2016, CalOptima met with CMS officials regarding underpayments for Cal MediConnect members residing in nursing homes in Orange and Los Angeles counties. The Medicare-Medicaid Coordination Office had identified this issue based on a study of facility costs and payment rates, and reached out to plans to discuss how to address the disparity. In January, CMS announced a targeted project in the two counties to improve health outcomes and adjust payment rates to better reflect costs of care. The initiative affects OneCare Connect and involves implementing interventions that reduce avoidable hospitalizations for nursing home residents. At the same time, CMS and DHCS will test new payment adjustments. Details regarding the quality and financial aspects of the new program are forthcoming. In the interim, CMS officials stated that this program should align well with our current efforts to continuously improve quality for OneCare Connect members in facilities.

Strategic Plan Distribution
Following your Board's approval in December of our 2017–2019 Strategic Plan, CalOptima developed a brochure summarizing the plan's framework, strategic priorities and building blocks. The brochures were distributed to more than 700 community partners to raise awareness about the agency's plans for the next three years.

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Financial Summary

December 2016

Nancy Huang

Interim Chief Financial Officer

FY 2016-17: Consolidated Enrollment

- December 2016 MTD:

  - Overall enrollment was 800,001 member months
    - Actual lower than budget by 3,893 or 0.5%
      - Medi-Cal: favorable variance of 1,058 members
      - OneCare Connect: unfavorable variance of 5,028 members
    - 0.2% or 1,442 increase from prior month
      - Medi-Cal: increase of 1,652 from November
      - OneCare: increase of 47 from November
      - PACE remained the same at 183 members
      - OneCare Connect: decrease of 257 from November

FY 2016-17: Consolidated Enrollment

- December 2016 YTD:

  - Overall enrollment was 4,792,229 member months
    - Actual lower than budget by 16,137 or 0.3%
      - Medi-Cal: favorable variance of 10,146 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 26,221 members or 19.8%
      - OneCare: unfavorable variance of 78 members or 1.1%
      - PACE: favorable variance of 16 members or 1.5%
    - 0.5% or 4,134 increase in enrollment from prior year

FY 2016-17: Consolidated Revenues

- December 2016 MTD:
  - Actual higher than budget by $2.5 million or 0.9%
    - Medi-Cal: favorable to budget by $19.9 million
      - $10.0 million for IGT and QAF revenue true-up from FY15
      - $5.9 million of LTC revenue for non-LTC members
      - $3.0 million of additional revenue for behavior health therapy benefits for Kaiser members, primarily prior year
    - OneCare Connect: unfavorable variance of $17.8 million
      - Unfavorable price variance of $7.4 million
        - CMC Medi-Cal capitation rate adjustment of ($5.8 million) for prior year
        - Current year price variance of ($1.6M) due to cohorts mix
      - Unfavorable volume variance of $10.4 million due to lower enrollment
    - OneCare: favorable to budget by $0.4 million

- December 2016 YTD:
  - Actual lower than budget by $10.7 million or 0.6%
    - Medi-Cal: favorable to budget by $67.0 million
    - OneCare Connect: unfavorable variance of $77.9 million

FY 2016-17: Consolidated Medical Expenses

- December 2016 MTD:
  - ➢ Actual higher than budget by $2.2 million or 0.8%
    - ▪ Medi-Cal: unfavorable variance of $19.5 million
      - MLTSS unfavorable variance $15.1 million
        - ➢ IHSS related unfavorable variance approximately $9.8 million
        - ➢ LTC unfavorable variance $5.4 million
          - $3.4 million higher LTC Claim expense due to less than anticipated members enrolling in OneCare Connect
          - $2.0 million variance from FY17 mandated rate increase accrual
      - Professional Claims unfavorable variance of $3.5 million due to higher IBNR expense in COD and Crossover categories
    - ▪ OneCare Connect: favorable variance of $17.1
      - Favorable price variance of $7.3 million
        - ➢ Lower than budget in LTC and prescription drug categories
      - Favorable volume variance of $9.8 million

FY 2016-17: Consolidated Medical Expenses (Cont.)

- December 2016 YTD:
  - Actual higher than budget by $9.2 million or 0.6%
    - Medi-Cal: unfavorable variance of $84.2 million
      - Unfavorable price variance of $81.2 million
        - IHSS estimated expense $35.9 million higher than budget
        - Long Term Care expense $22.5 million higher than budget
        - Facilities expense $16.0 million higher than budget
      - Unfavorable volume variance of $2.9 million
    - OneCare Connect: favorable variance of $73.6 million
      - Favorable volume variance of $50.7 million
      - Favorable price variance of $22.9 million

- Medical Loss Ratio (MLR):
  - December 2016 MTD: Actual: 96.3% Budget: 96.4%
  - December 2016 YTD: Actual: 96.8% Budget: 95.6%

FY 2016-17: Consolidated Administrative Expenses

- December 2016 MTD:
  - Actual lower than budget by $2.2 million or 19.0%
    - Salaries and Benefits: favorable variance of $1.8 million
    - Other categories: favorable variance of $0.4 million
- December 2016 YTD:
  - Actual lower than budget by $15.3 million or 22.0%
    - Salaries and Benefits: favorable variance of $10.5 million driven by lower than budgeted FTE of 437
    - Other categories: favorable variance of $4.8 million
- Administrative Loss Ratio (ALR):
  - December 2016 MTD: Actual: 3.3% Budget: 4.1%
  - December 2016 YTD: Actual: 3.2% Budget: 4.1%

FY 2016-17: Change in Net Assets

- December 2016 MTD:
  - $2.5 million surplus
  - $3.8 million favorable to budget
    - Higher than budgeted revenue of $2.5 million
    - Higher medical expenses of $2.2 million
    - Lower administrative expenses of $2.2 million
    - Higher investment income of $1.1 million

- December 2016 YTD:
  - $3.1 million surplus
  - $2.5 million unfavorable to budget
    - Lower than budgeted revenue of $10.7 million
    - Higher medical expenses of $9.2 million
    - Lower administrative expenses of $15.3 million
    - Higher investment income of $1.6 million

Enrollment Summary: December 2016

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
59,246	55,551	3,695	6.7%	Aged	348,935	330,936	17,999	5.4%
619	678	(59)	(8.7%)	BCCTP	3,744	4,058	(314)	(7.7%)
48,766	47,387	1,379	2.9%	*Disabled*	291,084	284,773	6,311	2.2%
334,073	341,728	(7,655)	(2.2%)	TANF Child	2,008,513	2,038,891	(30,378)	(1.5%)
101,296	109,238	(7,942)	(7.3%)	TANF Adult	616,009	657,470	(41,461)	(6.3%)
3,245	2,711	534	19.7%	LTC	19,568	16,137	3,431	21.3%
234,488	223,384	11,104	5.0%	MCE	1,389,942	1,335,387	54,555	4.1%
781,733	**780,675**	**1,058**	**0.1%**	**Medi-Cal**	**4,677,795**	**4,667,649**	**10,146**	**0.2%**
16,810	**21,838**	**(5,028)**	**(23.0%)**	**OneCare Connect**	**106,103**	**132,324**	**(26,221)**	**(19.8%)**
183	**190**	**(7)**	**(3.7%)**	**PACE**	**1,081**	**1,065**	**16**	**1.5%**
1,275	**1,191**	**84**	**7.1%**	**OneCare**	**7,250**	**7,328**	**(78)**	**(1.1%)**
800,001	**803,894**	**(3,893)**	**(0.5%)**	**CalOptima Total**	**4,792,229**	**4,808,366**	**(16,137)**	**(0.3%)**

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Financial Highlights: December 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
800,001	803,894	(3,893)	(0.5%)	Member Months	4,792,229	4,808,366	(16,137)	(0.3%)
284,981,150	282,457,437	2,523,714	0.9%	Revenues	1,680,187,510	1,690,855,264	(10,667,754)	(0.6%)
274,397,010	272,208,650	(2,188,360)	(0.8%)	Medical Expenses	1,625,698,293	1,616,486,375	(9,211,918)	(0.6%)
9,477,635	11,704,959	2,227,323	19.0%	Administrative Expenses	54,330,022	69,613,018	15,282,995	22.0%
1,106,505	**(1,456,172)**	**2,562,677**	**(176.0%)**	**Operating Margin**	**159,195**	**4,755,872**	**(4,596,677)**	**(96.7%)**
1,372,563	143,250	1,229,313	858.2%	Non Operating Income (Loss)	2,906,413	859,500	2,046,913	238.2%
2,479,068	**(1,312,922)**	**3,791,990**	**288.8%**	**Change in Net Assets**	**3,065,608**	**5,615,372**	**(2,549,764)**	**(45.4%)**
96.3%	96.4%	0.1%		Medical Loss Ratio	96.8%	95.6%	(1.2%)	
3.3%	4.1%	0.8%		Administrative Loss Ratio	3.2%	4.1%	0.9%	
0.4%	(0.5%)	0.9%		Operating Margin Ratio	0.0%	0.3%	(0.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.4	(1.5)	1.9	Medi-Cal	(2.7)	3.0	(5.7)
0.3	0.0	0.3	OneCare	(0.4)	0.2	(0.6)
0.3	0.2	0.0	OCC	2.3	3.0	(0.6)
0.1	(0.2)	0.4	PACE	0.9	(1.4)	2.3
1.1	**(1.5)**	**2.6**	**Operating**	**0.1**	**4.8**	**(4.6)**
1.3	0.1	1.2	Inv./Rental Inc, MCO tax	2.9	0.9	2.1
1.3	**0.1**	**1.2**	**Non-Operating**	**2.9**	**0.9**	**2.1**
2.5	**(1.3)**	**3.8**	**TOTAL**	**3.1**	**5.6**	**(2.5)**

Consolidated Revenue & Expense: December 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	552,963	228,770	781,733	1,275	16,810	183	800,001
REVENUES							
Capitation Revenue	$ 151,057,449	$ 103,728,418	$ 254,785,867	$ 1,740,853	$ 27,219,789	$ 1,234,641	$ 284,981,150
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	151,057,449	103,728,418	254,785,867	1,740,853	27,219,789	1,234,641	284,981,150
MEDICAL EXPENSES							
Provider Capitation	39,088,525	35,916,879	75,005,405	475,522	7,379,996		82,860,922
Facilities	29,221,584	31,699,067	60,920,651	246,359	6,576,350	207,168	67,950,528
Ancillary				47,325	774,298	-	821,623
Skilled Nursing				110,029	5,158,647	-	5,268,676
Professional Claims	13,447,567	7,858,631	21,306,197	-	-	210,989	21,517,186
Prescription Drugs	17,552,654	15,536,252	33,088,906	445,054	4,329,045	86,791	37,949,797
Quality Incentives					-		-
Long-term Care Facility Payments	46,560,982	6,134,677	52,695,659	-	-	2,297	52,697,956
Contingencies	-	-	-	-	-	-	-
Medical Management	3,129,613	-	3,129,613	30	1,047,645	391,666	4,568,953
Reinsurance & Other	(347,500)	912,437	564,937	4,500	90,464	101,466	761,368
Total Medical Expenses	148,653,425	98,057,943	246,711,368	1,328,819	25,356,444	1,000,378	274,397,010
Medical Loss Ratio	**98.4%**	**94.5%**	**96.8%**	**76.3%**	**93.2%**	**81.0%**	**96.3%**
GROSS MARGIN	**2,404,024**	**5,670,475**	**8,074,499**	**412,034**	**1,863,345**	**234,263**	**10,584,140**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,211,983	(42,646)	864,690	95,288	6,129,315
Professional Fees			62,924	20,889	2,308	(9,691)	76,430
Purchased Services			797,821	37,822	178,224	5,821	1,019,688
Printing and Postage			320,761	34,085	232,019	275	587,140
Depreciation and Amortization			357,681			2,065	359,746
Other Expenses			916,914	0	35,738	8,175	960,827
Indirect Cost Allocation, Occupancy Expense			48,909	13,811	279,779	1,989	344,488
Total Administrative Expenses			7,716,993	63,961	1,592,759	103,923	9,477,635
Admin Loss Ratio			**3.0%**	**3.7%**	**5.9%**	**8.4%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			357,506	348,073	270,586	130,340	1,106,505
INVESTMENT INCOME			-	-	-	-	1,333,795
NET RENTAL INCOME			-	-	-	-	6,121
NET GRANT INCOME			32,648	-	-	-	32,648
CHANGE IN NET ASSETS			**$ 390,154**	**$ 348,073**	**$ 270,586**	**$ 130,340**	**$ 2,479,068**
BUDGETED CHANGE IN ASSETS			(1,471,309)	19,289	225,345	(229,497)	(1,312,922)
VARIANCE TO BUDGET - FAV (UNFAV)			1,861,463	328,783	45,241	359,837	3,791,990

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Consolidated Revenue & Expense: December 2016 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	3,986,735	691,060	4,677,795	7,250	106,103	1,081	4,792,229
REVENUES							
Capitation Revenue	$ 1,156,299,527	$ 313,684,901	$ 1,469,984,429	$ 7,696,695	$ 194,860,506	$ 7,645,881	$ 1,680,187,510
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	1,156,299,527	313,684,901	1,469,984,429	7,696,695	194,860,506	7,645,881	1,680,187,510
MEDICAL EXPENSES							
Provider Capitation	325,265,834	120,093,879	445,359,713	2,362,691	44,289,857		492,012,261
Facilities	257,365,115	97,882,871	355,247,986	1,964,601	57,201,847	1,431,547	415,845,981
Ancillary				261,630	4,517,468	-	4,779,098
Skilled Nursing				304,101	36,113,339	-	36,417,440
Professional Claims	91,469,918	23,468,015	114,937,934	-	-	1,217,680	116,155,614
Prescription Drugs	156,770,274	50,153,940	206,924,214	2,638,435	33,328,250	513,463	243,404,362
Quality Incentives					-		-
Long-term Care Facility Payments	267,935,329	18,483,483	286,418,812	-	-	23,511	286,442,323
Contingencies	-	-	-	-	-	-	-
Medical Management	17,555,138	-	17,555,138	57,008	6,067,409	2,357,139	26,036,695
Reinsurance & Other	598,341	2,833,536	3,431,878	26,895	564,336	581,410	4,604,518
Total Medical Expenses	1,116,959,950	312,915,725	1,429,875,675	7,615,362	182,082,506	6,124,750	1,625,698,293
Medical Loss Ratio	**96.6%**	**99.8%**	**97.3%**	**98.9%**	**93.4%**	**80.1%**	**96.8%**
GROSS MARGIN	**39,339,577**	**769,177**	**40,108,754**	**81,333**	**12,778,000**	**1,521,131**	**54,489,218**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			31,091,637	88,965	4,635,382	546,460	36,362,444
Professional Fees			683,740	98,070	308,290	5,000	1,095,099
Purchased Services			4,084,093	135,405	804,713	21,518	5,045,731
Printing and Postage			1,222,255	58,268	465,555	2,000	1,748,078
Depreciation and Amortization			1,834,477			12,247	1,846,725
Other Expenses			5,830,538	1,692	204,718	35,991	6,072,938
Indirect Cost Allocation, Occupancy Expense			(2,006,012)	140,030	4,011,099	13,891	2,159,008
Total Administrative Expenses			42,740,728	522,430	10,429,757	637,107	54,330,022
Admin Loss Ratio			**2.9%**	**6.8%**	**5.4%**	**8.3%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			(2,631,974)	(441,097)	2,348,243	884,024	159,195
INVESTMENT INCOME			-	-	-	-	2,895,674
NET RENTAL INCOME			-	-	-	-	29,776
NET GRANT INCOME			(19,659)	-	-	-	(19,659)
OTHER INCOME			623	-	-	-	623
CHANGE IN NET ASSETS			**$ (2,651,010)**	**$ (441,097)**	**$ 2,348,243**	**$ 884,024**	**$ 3,065,608**
BUDGETED CHANGE IN ASSETS			3,021,093	171,808	2,981,950	(1,418,978)	5,615,372
VARIANCE TO BUDGET - FAV (UNFAV)			(5,672,103)	(612,905)	(633,707)	2,303,002	(2,549,764)

Balance Sheet:
As of December 2016

ASSETS		
Current Assets		
	Operating Cash	$686,243,544
	Catastrophic Reserves	11,637,915
	Investments	1,291,463,357
	Capitation receivable	323,152,084
	Receivables - Other	24,819,684
	Prepaid Expenses	11,088,967
	Total Current Assets	**2,348,405,551**
Capital Assets	Furniture and equipment	33,303,693
	Leasehold improvements	7,785,652
	505 City Parkway West	49,269,863
		90,359,207
	Less: accumulated depreciation	(34,882,362)
	Capital assets, net	**55,476,846**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	3,158,986
	Long term investments	527,676,111
	Total Board-designated Assets	530,835,097
	Total Other Assets	**531,135,097**
	Deferred outflows of Resources - Pension Contributions	3,787,544
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,940,020,510**

LIABILITIES & FUND BALANCES	
Current Liabilities	
Accounts payable	$41,160,847
Medical claims liability	717,681,422
Accrued payroll liabilities	8,691,224
Deferred revenue	962,318,501
Deferred lease obligations	267,070
Capitation and withholds	505,544,188
Total Current Liabilities	**2,235,663,252**
Other employment benefits liability	28,926,866
Net Pension Liabilities	10,543,065
Long Term Liabilities	100,000
TOTAL LIABILITIES	**2,275,233,183**
Deferred inflows of Resources - Excess Earnings	502,900
Deferred inflows of Resources - changes in Assumptions	1,651,640
Tangible net equity (TNE)	94,663,492
Funds in excess of TNE	567,969,295
Net Assets	**662,632,787**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES	**2,940,020,510**

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Board Designated Reserve and TNE Analysis
As of December 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	145,148,288				
	Tier 1 - Logan Circle	144,852,055				
	Tier 1 - Wells Capital	144,950,870				
Board-designated Reserve		434,951,213	277,968,755	437,668,289	156,982,458	(2,717,076)
TNE Requirement	Tier 2 - Logan Circle	95,883,884	94,663,492	94,663,492	1,220,392	1,220,392
	Consolidated:	**530,835,097**	**372,632,247**	**532,331,781**	**158,202,850**	**(1,496,685)**
	Current reserve level	1.99	1.40	2.00		

HN Enrollment Summary - Medi-Cal

Health Network Name	JANUARY 2017	Percentage
CHOC Health Alliance (PHC20)	153,269	19.7%
Monarch Family HealthCare (SRG68)	87,705	11.3%
Arta Western Health Network (SRG66)	75,648	9.7%
CalOptima Community Network (CN)	69,947	9.0%
Family Choice Health Network (PHC21)	48,091	6.2%
Kaiser Permanente (HMO04)	45,199	5.8%
Alta Med Health Services (SRG69)	40,949	5.3%
United Care Medical Network (SRG67)	35,016	4.5%
Prospect Medical Group (SRG63)	34,961	4.5%
Noble Mid-Orange County (SRG64)	33,409	4.3%
Talbert Medical Group (SRG65)	24,776	3.2%
AMVI Care Health Network (PHC58)	22,755	2.9%
Heritage - Regal Medical Group (HMO15)	3,802	0.5%
OC Advantage (PHC35)	951	0.1%
Total Health Network Capitated Enrollment	**676,476**	**87.1%**
CalOptima Direct (all others)	99,894	12.9%
Total Medi-Cal Enrollment	**776,370**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	JANUARY 2017	Percentage
Monarch HealthCare (PMG53DE)	681	49.6%
AMVI/Prospect Medical Group (PMG27DE)	402	29.3%
Talbert Medical Group (PMG52DE)	110	8.0%
Family Choice Medical Group (PMG21DE)	79	5.7%
Arta Western Health Network (PMG66DE)	44	3.2%
Alta-Med (PMG69DE)	34	2.5%
United Care Medical Group (PMG67DE)	20	1.5%
Noble Mid Orange County (PMG64DE)	4	0.3%
Total OneCare Enrollment	**1,374**	**100.0%**

HN Enrollment Summary – OneCare Connect

Health Network Name	JANUARY 2017	Percentage
Monarch HealthCare (SRG53DE)	5,265	31.7%
Propect Medical Group (SRG63DB)	3,150	19.0%
Family Choice Medical Group (SRG81DB)	1,919	11.6%
CalOptima Community Network (CN)	1,827	11.0%
Talbert Medical Group (SRG52DB)	1,219	7.3%
United Care Medical Group (SRG67DB)	636	3.8%
Arta Western Health Network(SRG66DB)	603	3.6%
AMVI Care Health Network (PHC58DB)	592	3.6%
Alta-Med (SRG69DB)	568	3.4%
Noble Mid Orange County (SRG64DB)	446	2.7%
Heritage - Regal Medical Group (HMO15)	264	1.6%
OC Advantage (PHC35DB)	115	0.7%
Total OneCare Connect Enrollment	**16,604**	**100.0%**


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Managed Behavioral Health Organization (MBHO) Update

Provider Advisory Committee

February 9, 2017

Donald Sharps, M.D.

Medical Director, Behavioral Health

MBHO Status Update

- CalOptima has transitioned the MBHO to Magellan.
- All members access behavioral health services by calling the CalOptima Behavioral Health Line at 855-877-3885.
- Magellan has a local call center and clinical team.

Program	MBHO (Previous)	MBHO (1/1/2017)
Medi-Cal	Beacon	Magellan
OC/OCC	Windstone	

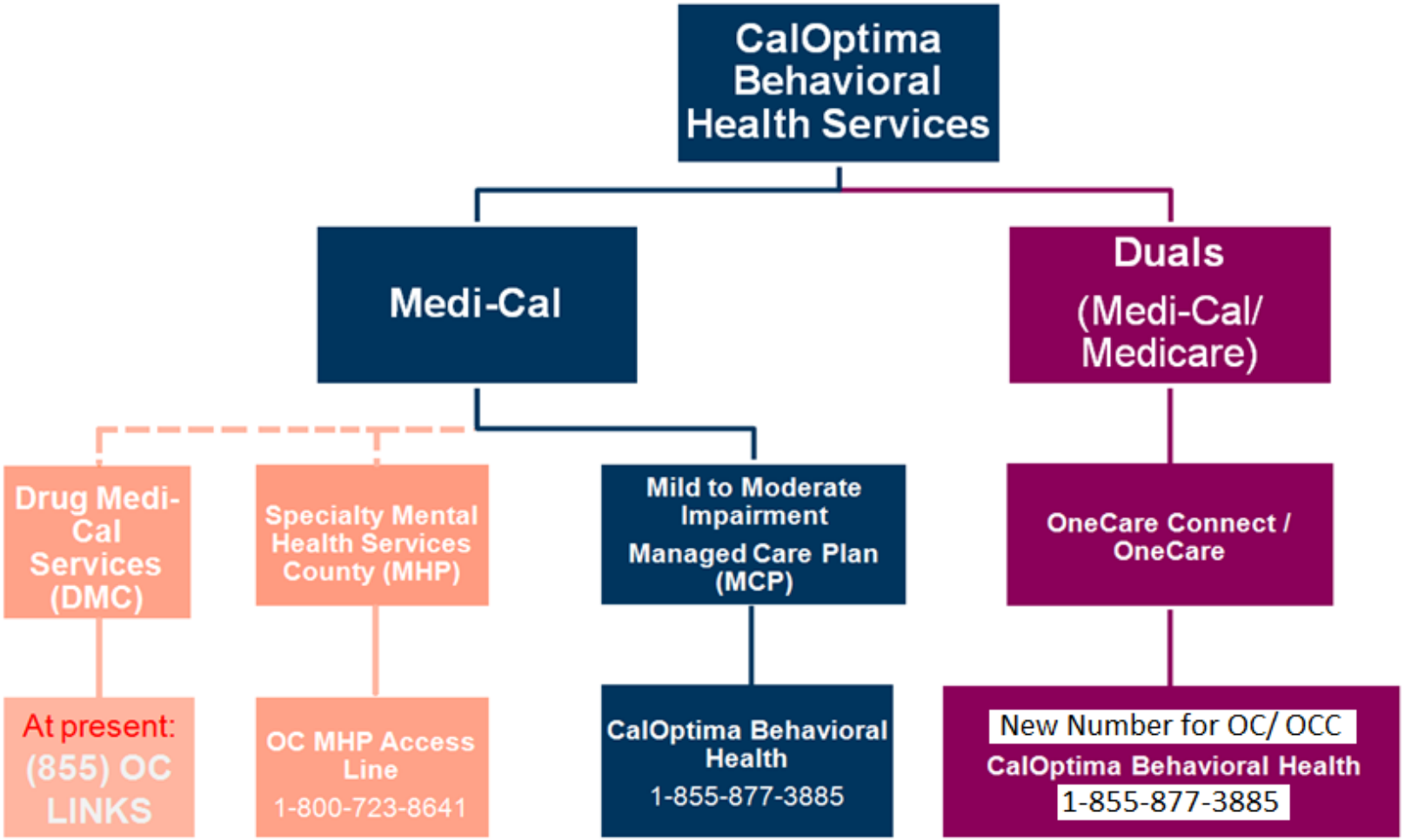
Medi-Cal Network and Transition of Care

- **Medi-Cal Network Development — Behavioral Health (BH) Practitioners Only**
  - 581 targeted providers but, for continuity, the recruitment focus was on 327 providers with 8,587 members from July 1–September 30, 2016.
    - 274 of 327 completed/received provider contracts.
    - Represents 83 percent of providers and 95 percent of members.
- **Medi-Cal Network Development — Applied Behavior Analysis (ABA) Provider Groups**
  - 63 targeted provider groups for recruitment to provide continuity of services to 1,865 members who have current open authorizations.
    - 49 of 63 completed/received provider contracts.
    - Represents 83 percent of providers and 95 percent of members.

Medi-Cal Network and Transition of Care (Cont.)

- **Continuity of Care Requests**
  - 125+ requests in progress
    - Few have requested new provider instead of staying with current and no denials
  - 95+ requests resolved due to Magellan contracting with providers

CalOptima BH Services (1/1/17)



Psychiatric Hospital, Emergency Room, Medical-Surgical Units and Long-Term Care

- Medi-Cal members
  - Psych hospital, ER/med-surg unit, **acute** long-term care
    - BH professional services — County/Beacon 800-723-8641
    - Psychiatric hospital facility charges — County
  - **Non-acute** long-term care
    - BH professional services — **Magellan 855-877-3885**

- Medi-medi members in OneCare Connect/OneCare
  - Psych hospital, ER/med-surg unit, long-term care
    - BH professional services — **Magellan 855-877-3885**

Referral for BH Services (Effective 1/1/17)

Call **CalOptima Behavioral Health** at:

855-877-3885

For screening and referral to mental health services.

This number is available 24 hours a day, 7 days a week.

TTY/TDD: **800-735-2929**

Behavioral Health Integration Department

- Vision and Purpose
  - Integrate behavioral health at all levels of CalOptima operations.
  - Provide oversight and accountability to behavioral health services provided to CalOptima members.
  - Serve as subject matter experts for behavioral health (mental health and substance use disorder) for all CalOptima programs.

Questions?

Please email behavioralhealth@caloptima.org

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


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CalOptima Pay for Value Results

Measurement Year 2015 (HEDIS 2016)

Richard Bock, Deputy Chief Medical Officer
Caryn Ireland, Executive Director, Quality and Analytics

Program Objectives and Value

- Recognize and reward Health Networks and their physicians for demonstrating quality performance
- To provide comparative information for members, providers and the public on CalOptima's performance
- To provide industry standard benchmarks and data driven feedback to the Health Networks on their quality improvement efforts
- Focus on triple aim:
  - ❖better population health
  - ❖better care for individuals
  - ❖lower healthcare costs

P4P Medi-Cal Measures (Clinical Domain)

Adult Measures	Child Measures
Breast Cancer Screening (BCS)	Well-Care Visits in the 3-6 years of life (W34)
Cervical Cancer Screening (CCS)	Adolescent Well-Care Visits (AWC)
Comprehensive Diabetes Care (CDC) HbA1c testing	Childhood Immunization Status Combo 10 (CIS)
Comprehensive Diabetes Care (CDC) Retinal Eye Exam	Appropriate Testing for Children with Pharyngitis (CWP)
Adult's Access to Preventive Care Services (AAP)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
	Medication Management for People with Asthma (MMA)

P4P Medi-Cal CAHPS Measures (Patient Experience Domain)

Child and Adult Measures
Getting appointment with a Specialist
Timely Care and Service
Rating of Primary Care Physician
Rating of All Healthcare

2016 Total Medi-Cal Allocations (Clinical and CAHPS Measures)

Total Accrual	HEDIS Allocation	Survey Allocation	Total Amount Paid	Remaining Allocated Dollars	Percent Remaining
$ 14,845,614.00	$ 2,642,309.93	$ 1,293,032.75	$ 3,935,342.68	$ 10,910,271.32	73.49%

2016 Allocations by Health Network (Medi-Cal Measures)

Health Network	% HEDIS Earned	% Survey Earned	% of Total Amount Paid	Percentage Remaining
HN - A	21.67%	0.00%	21.67%	78.33%
HN - B	10.83%	10.00%	20.83%	79.17%
HN - C	5.42%	5.63%	11.04%	88.96%
HN - D	16.25%	12.50%	28.75%	71.25%
HN - E	32.50%	8.75%	41.25%	58.75%
HN - F	10.83%	16.25%	27.08%	72.92%
HN - G	10.83%	8.13%	18.96%	81.04%
HN - H	5.42%	0.00%	5.42%	94.58%
HN - I	21.67%	11.88%	33.54%	66.46%
HN - J	21.67%	15.00%	36.67%	63.33%
HN - K	21.67%	10.00%	31.67%	68.33%
TOTAL	**17.80%**	**8.71%**	**26.51%**	**73.49%**

P4P Quality OneCare Measures (Clinical Domain)

Breast Cancer Screening (BCS)	Comprehensive Diabetes Care (CDC) HbA1c Screening
Colorectal Cancer Screening (COL)	Comprehensive Diabetes Care (CDC) HbA1c Control (<8%)
Adults access to Preventive / Ambulatory Health Services (AAP)	Comprehensive Diabetes Care (CDC) Retinal Eye Exam
	Comprehensive Diabetes Care (CDC) Nephropathy Screening

P4P OneCare CAHPS Measures (Patient Experience Domain)

OneCare Measures
Getting Needed Care
Getting Appointments and Care Quickly
Overall Rating of Healthcare Quality
Annual Flu Vaccine

2016 Total Allocations (OneCare Measures)

Total Accrual	HEDIS Allocation	Survey Allocation	Total Amount Paid	Remaining Allocated Dollars	Percent Remaining
$2,492,469.84	$ 327,068.28	$258,186.00	$ 585,254.28	$ 1,907,215.56	76.52%

2016 Allocation by Health Networks (OneCare Measures)

Health Network	% HEDIS Earned	%Survey Earned	% of Total Amount Paid	Percentage Remaining
HN-I	5.35%	12.52%	17.88%	82.12%
HN-II	16.06%	3.13%	19.19%	80.81%
HN-III	0.00%	0.00%	0.00%	100.00%
HN-IV	5.35%	3.13%	8.48%	91.52%
HN-V	10.71%	18.79%	29.49%	70.51%
HN-VI	0.00%	12.52%	12.52%	87.48%
HN-VII	32.12%	0.00%	32.12%	67.88%
HN-VIII	0.00%	12.52%	12.52%	87.48%
TOTAL	**13.12%**	**10.36%**	**23.48%**	**76.52%**

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Actions:

- Incentives earned were mailed in December, 2016
- Reviewing 2015 P4V results with HN operations staff during Joint Operating Meeting and/or HN/CalOptima Quality Team meeting
- Comparing 2015 P4V results with 2016 YTD performance with HN staff and discussing specific actions to help improve scores for 2017

Pay for Value:
Measurement Year 2016 Changes

- Similar Clinical & CAHPS measures, however:
  - HNs responsible for both Adult & Child Measures
- Introduced Display Measures
  - IHA, Ambulatory Care (Outpatient & ER Visits, Readmissions)
- Retired OneCare Program
- Added OneCare Connect
- Changed Payment Methodology
  - Payment for Performance & Improvement
  - Added Acuity Scale (SPD 4X, TANF 1X)

Medi-Cal P4V Clinical Measures

Measurement Year 2017 Measures	
Adult Measures	**Child Measures**
Adult's Access to Preventive Care Services (AAP)	Children's Access to Primary Care Physicians (CAP)
Breast Cancer Screening (BCS)	Well-Child Visits in the 3-6 Years of life (W34)
Cervical Cancer Screening (CCS)	Adolescent Well-Care Visits (AWC)
Comprehensive Diabetes Care (CDC): HbA1C Testing	Childhood Immunization Status (CIS) Combo 10
Comprehensive Diabetes Care (CDC): Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis (CWP)
Medication Management for People with Asthma (MMA)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
* No change in clinical measures from 2016	Medication Management for People with Asthma (MMA)

MediCal P4V CAHPS Measures

Measurement Year 2017 Measures
Child and Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of Primary Care Physician
Rating of All HealthCare
* No change in survey measures from 2016

OCC P4V Clinical Measures

Measurement Year 2017 Measures

1. Plan All Cause Readmissions
2. Behavioral Health:
   - Antidepressant Medication Management
3. Controlling Blood Pressure
4. Medication Adherence for Oral Anti-Diabetes Medications (Part D measure)

* No change in clinical measures from 2016;
* Clinical measures weight changed from 100% to 60% due to addition of Member Experience component for 2017

OCC P4V CAHPS Measures

Measurement Year 2017 Measures
Child and Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of Primary Care Physician
Rating of All HealthCare
* Weight=40%

New: CalOptima Community Network (CCN) Providers

- CCN P4V measures and scoring methodology are the same as for the HNs.
- Payment distribution is in discussion with P4V steering committee
- Details to be vetted and brought for BOD approval

Proposed 2017 Display Measures

- Display Measures are new measures that may be included in future pay for value programs
- These measures were not eligible for payment for 2016 measurement year performance
- CalOptima will include display measures on the monthly health network P4V prospective rate reports for monitoring purposes
- Display Measure:
  - ❖Initial Health Assessment (IHA)—will remain display measure for 2017
- Retired Display Measures:
  - ❖Ambulatory Care (Outpatient and ER visits)
  - ❖Readmissions

2017 Payment Methodology, Proposed

Population Included	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Scoring for Measure Performance:	
A relative point system, by measure, based on: • NCQA National HEDIS Percentiles (clinical) 50th percentile minimum • NCQA National CAHPS Percentiles (satisfaction) • Relative HN Improvement year-over-year x CalOptima (CO) improvement YOY • Minimum denominator size for eligible measure reduced from 100 to 30 eligible members	
Clinical Measures = **60%** of the Total	**CAHPS Measures** = **40%** of the Total
Performance = 50% (relative performance x weighted pmpm)	**Improvement = 50%** (relative Impr x CO Impr factor x pmpm)

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IMPACT Medi-Cal Growth in Orange County

Nearly a Quarter Million Residents May Lose Access to Care

CalOptima is a community-based health plan that serves Orange County's low-income Medi-Cal members. In 2014, when the Affordable Care Act expanded eligibility for Medi-Cal, CalOptima welcomed a new group of Orange County residents as members. The uninsured rate in Orange County went down to 8.7 percent in 2015, compared with 16.2 percent in 2013. Today, the Medi-Cal Expansion population is 234,000, and CalOptima's Medi-Cal Expansion revenue is $1.1 billion, which goes to pay local private-sector health care providers. This fact sheet explains the impact of Medi-Cal growth in terms of access to care and local economic benefits.

Medi-Cal growth has resulted in tremendous gains, which may be at risk with any changes to the program.

Expansion Members & Dollars

234,000

30% of CalOptima membership

$1.1 Billion

30% of CalOptima revenue

Source: CalOptima membership and finance data

Community Health Centers

INCREASE in number of centers:

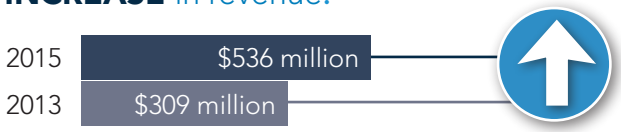
Up 13 Centers

72 community health centers in Orange County today, compared with 59 community health centers in 2013

Source: Coalition of Orange County Community Health Centers

Hospitals

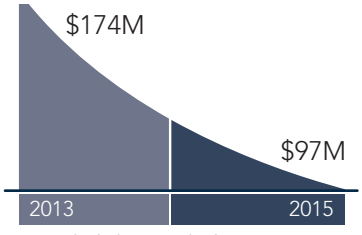
INCREASE in revenue:



Payments to hospitals in 2015, compared with 2013

Up $227M

DECREASE in bad debt & charity care:



Bad debt and charity care

$77M

less bad debt & charity care

Source: Office of Statewide Health Planning and Development

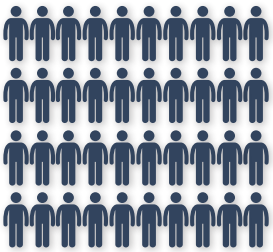
Health Networks

INCREASE in revenue:

Payments to doctors and health networks in 2015, compared with 2013

Up $565M

WORKFORCE



400

jobs created

Estimated jobs created at contracted health networks since 2013

Source: CalOptima contracted health networks

CalOptima
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Medi-Cal Growth in Orange County

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and most of its provisions went into effect on January 1, 2014. President Trump has made the repeal and replacement of the ACA a central part of his domestic policy agenda. Key Republican leaders, including Speaker of the House Paul Ryan and President Trump's nominee for Secretary of Health and Human Services, Rep. Tom Price, have shared policy priorities to repeal and replace substantial portions of the law, including the optional expansion of Medicaid. This is likely to have a significant impact on California, given the sizeable growth in the state's Medicaid population under the ACA. This brief highlights the major implications of a potential rollback of Medicaid expansion and the impact it would have on Orange County.

What is Medicaid?

Medicaid is a joint federal and state health care program for the poor, created by the 1965 amendments to the Social Security Act. Today, more than 70 million people nationwide — mostly children, seniors and people with disabilities[1] — have access to health care through Medicaid. Access to the program is an entitlement. In other words, if a person is eligible, then he or she is guaranteed access. Individuals and families at or below the Federal Poverty Level, approximately $12,000 per year for an individual or $24,000 per year for a family of four, are eligible for Medicaid coverage.

Each state administers its own Medicaid program — California's is known as Medi-Cal — under federal rules. The program is jointly funded by states and the federal government. The current Medicaid financing system is a per-member federal match, known as the Federal Medical Assistance Percentage, or FMAP. The FMAP is customized to each state depending on the state's per capita income, compared with the national average. Each quarter, states report their Medicaid costs to the federal government, and those costs are matched at the state's FMAP. California's match is 50/50. Generally, for each Medi-Cal dollar, 50 cents is from the state and 50 cents is from the federal government.

How Did The ACA Affect Medicaid?

The ACA has had a broad impact on the health care industry, especially the Medicaid program. In its original form, the law mandated that states expand their Medicaid programs. However, the Supreme Court's 2012 ruling in National Federation of Independent Business v. Sebelius made expansion an optional part of the ACA. In states that chose to implement the expansion, eligibility was expanded to include individuals with income up to 138 percent of the Federal Poverty Level, approximately $16,000 for an individual and $33,000 for a family of four. Importantly, coverage for the Medicaid expansion population was 100 percent funded by the federal government for the first three years of the program. Beginning in calendar year 2017, states are responsible for a share of this cost, starting at 5 percent and increasing to 10 percent by 2020. In California's proposed state budget, Gov. Brown estimates that spending related to Medi-Cal expansion will be $18.9 billion in Fiscal Year (FY) 2017–18, and he has allocated $1.6 billion from the General Fund to cover the state's share of this cost.[2]

How was California Impacted?

California is one of 32 states that chose to expand Medicaid, authorizing the change with the passage of Senate Bill (SB) X1-1 (2013) and Assembly Bill (AB) X1-1 (2013). Since 2014, approximately 3.7 million Californians have gained health care coverage through Medi-Cal expansion (MCE).[3] MCE has helped reduce the number of uninsured Californians by half, from 17.2 percent in 2013 to 8.6 percent in 2015.[4] MCE enrollees gain access to Medi-Cal's core set of health benefits, including doctor visits, hospital care, immunizations, pregnancy-related services and nursing home care. Further, under the ACA, Medi-Cal health plans must offer their members a comprehensive array of services, including mental health and substance use disorder services, and preventive and wellness services, among others.

MCE has had a broadly positive affect on the state's health care infrastructure. For example, MCE has contributed to a 70 percent increase in hospital Medi-Cal revenue from 2011 to 2015.[5] In turn, this has helped California hospitals reduce bad debt (defined as payment for services anticipated, but not received) by 38 percent, from $5.1 billion in 2011 to $3.1 billion 2015.[6]

Repeal of the ACA will have a significant impact on California because many of the state's laws implementing the federal legislation have tie-back language that sunsets state provisions if the ACA is repealed or amended. SB X1-1 in particular includes language that would end Medi-Cal expansion within 12 months if the federal match falls below 70 percent before January 1, 2018.

How Was Orange County Impacted?

Any changes related to the MCE population would be keenly felt in Orange County, as CalOptima has more than 230,000 MCE members and receives more than $1.1 billion in funding related to this population. Expansion has provided these members with access to high-quality and cost-effective care. In September 2016, the National Committee for Quality Assurance awarded CalOptima a quality score of 4 out of 5 — the highest rating in California and in the top 10 percent nationwide. The score measures preventive care, treatment and customer satisfaction. Orange County's MCE dollars have also been efficiently managed. CalOptima maintains one of the lowest overhead rates — approximately 4 percent — among both public and private health plans in California.

At the heart of CalOptima's system of care is the plan's robust public-private partnership with local physicians, hospitals, health networks, pharmacies and other ancillary providers. This ensures access and offers choice to members. CalOptima contracts with 13 commercial health networks, which offer CalOptima members access to nearly 2,000 primary care providers and 6,000 specialists. The table below provides membership data for CalOptima's contracted health network partners.

Contracted Private-Sector Health Networks

Network	Medi-Cal Classic Members	Medi-Cal Expansion Members
AltaMed Health Services	23,336	18,427
AMVI Care Health Network	11,675	11,116
Arta Western Health Network	50,174	25,993
CHOC Health Alliance	150,070	4,347
Family Choice Health Network	27,093	21,379
Heritage	1,764	2,127
Kaiser Permanente	33,338	12,128
Monarch Family HealthCare	53,707	34,936
Noble Mid-Orange County	17,896	15,879
OC Advantage	335	644
Prospect Medical Group, Inc	17,672	17,428
Talbert Medical Group	14,212	10,819
United Care Medical Group	19,438	15,905

CalOptima also partners with 39 hospitals across the region, including CHOC Children's in Orange, Hoag Memorial Hospital Presbyterian in Newport Beach and St. Jude Medical Center in Fullerton.

If MCE was rolled back as part of repealing the ACA, there would be major impacts to Orange County providers, health networks and hospitals. Due to growth in the Medi-Cal program, CalOptima has increased payments to contracted health networks by $565 million ($928 million in 2015, compared with $363 million in 2013) and increased payments to contracted hospitals by $227 million ($536 million in 2015, compared with $309 million in 2013). In part, this has contributed to Orange County's hospitals experiencing a 44 percent decrease in bad debt and charity care ($97 million in 2015, compared with $174 million in 2013). Overall, the Orange County uninsured population has decreased by 45 percent, going from 505,000 in 2013 to 276,000 in 2015.[7]

A rollback of MCE could also have a significant impact on Orange County's local economy due to the potentially drastic reduction in federal spending. An estimated 400 jobs have been created at CalOptima's contracted health networks related to MCE. Overall, ACA repeal could lead to Orange County losing 15,000 jobs in health care and other industries.[8]

Conclusion

While CalOptima recognizes the health care industry's continuous evolution, the new federal landscape has the potential to fundamentally change Medi-Cal in Orange County. In this environment, Orange County can benefit by amplifying our longstanding strength — the public-private partnership between CalOptima and private-sector hospitals, health networks and ancillary providers to ensure that low-income residents have guaranteed access to care. CalOptima intends to participate in Medicaid reform discussions to highlight our unique partnership and our commitment to delivering access to high-quality, cost-effective care.

About CalOptima

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

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Endnotes

[1] "Medicaid: An Overview," Congressional Research Service, January 2014.
[2] 2017–18 Governor's Budget Summary, p. 53, www.ebudget.ca.gov/2017-18/pdf/BudgetSummary/FullBudgetSummary.pdf, accessed January 31, 2017.
[3] "California's Projected Economic Losses Under ACA Repeal," UC Berkeley Center for Labor Research and Education, December 2016.
[4] U.S. Census Bureau, American Community Survey, 2013–15, Table A1: Population Without Health Insurance.
[5] Office of Statewide Health Planning and Development, 2011–15 Summary Trends – Hospital Quarterly Financial and Utilization Data.
[6] Ibid.
[7] "ACA Repeal in California: Who Stands to Lose?" UCLA Center for Health Policy and Research and UC Berkeley Center for Labor Research and Education, December 2016.
[8] "Fact Sheet: What does Orange County Stand to Lose under ACA Repeal?" UCLA Center for Health Policy and Research and UC Berkeley Center for Labor Research and Education, January 2017.

FY 2017–18 State Budget Proposal Analysis and CalOptima Impacts

January 2017

Overview

On January 10, 2017, the Governor released his 2017–18 state budget proposal. The total proposal is $179.5 billion, with General Fund spending at $122.5 billion, which is essentially flat compared with the current fiscal year's General Fund. Of note, in both his press conference and the budget proposal summary, the Governor mentioned the importance of the May revision with respect to the FY 2017–18 budget proposal given the significant financial uncertainties at both the federal and state level.

At the federal level, the budget, by and large, assumes the continuation of existing federal policy and does not speculate regarding the potential fiscal impacts of policy changes suggested by the incoming presidential administration and new Congress. At the same time, the Governor acknowledged the significant impact that any potential changes at the federal level could have on California.

Medi-Cal Budget

FY 2017–18 Proposed Medi-Cal Budget

General Fund	$19.1 billion (7 percent increase from 2016 Budget Act)
Federal Funds	$66.8 billion (includes $17.6 billion for MCE)
Other	$16.7 billion (includes $1.2 billion in Proposition 56 funds)
Total	**$102.6 billion**

The increase in General Fund dollars allocated to Medi-Cal is based on an estimated enrollment of 14.3 million members.

Please note that the federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as Medi-Cal classic, there is a 50/50 match. For the Medi-Cal expansion (MCE) population, there is an enhanced federal match (95/5 for calendar year 2017 and 94/6 for calendar year 2018). For the Children's Health Insurance Program (CHIP) population, there is currently a 88/12 match. The "other" portion of the Medi-Cal budget accounts for state funds drawn from the special funds pool, which includes, for instance, tobacco tax dollars designated for Medi-Cal. A large portion of the revenue raised by Proposition 56's expansion of the tobacco tax, approved by California voters in November 2016, will be designated for supplementing the state's Medi-Cal budget. Accordingly, the budget estimates that Medi-Cal will receive $1.2 billion in Proposition 56-related funding in FY 2017–18.

Most significant to CalOptima is the continuation of the Cal MediConnect program, which includes CalOptima's OneCare Connect — our coordinated health plan for dual eligibles (members with both Medicare and Medi-Cal coverage) — even as the broader Coordinated Care Initiative (CCI) is discontinued. CCI's discontinuation means that administration of In-Home Supportive Services (IHSS) will be transferred back to counties from managed care plans and that new state legislation will be required to authorize Cal MediConnect.

These and other major issues pertinent to CalOptima are addressed below.

Continuation of Cal MediConnect

Cal MediConnect is part of CCI, which operates in seven counties and consists of two additional parts: the integration of Medi-Cal long-term services and supports into managed care (MLTSS), and changes to the management and financing of IHSS. Under CCI, the state assumed bargaining responsibilities for IHSS and instituted a new maintenance-of-effort (MOE) funding requirement in place of the traditional county share-of-cost arrangement. CCI's authorizing statute predicates the continuation of the program on a yearly evaluation of its cost-effectiveness by the California Department of Finance (DOF). Given this, there was significant uncertainty surrounding CCI's future prior to the release of the budget proposal. However, the budget proposes to continue most elements of the CCI, including Cal MediConnect, but takes IHSS from the plans and returns the administration of this benefit to the county.

Cal MediConnect's extension means that CalOptima's OneCare Connect members will be able to continue enjoying access to the enhanced services and benefits available through the plan. This is the culmination of two years of extensive advocacy by CalOptima and other CCI health plans. DOF determined that Cal MediConnect plans have shown the potential to improve the quality of care for duals and achieve long-term cost

savings. Therefore, the budget proposes to extend Cal MediConnect until December 31, 2019. The budget also supports the continued integration of MLTSS into managed care, with the exception of IHSS.

IHSS

Removing IHSS from CCI means IHSS reverts to its prior funding arrangement, with counties assuming 35 percent of the nonfederal portion of IHSS costs, which will net the state $626 million in savings. For CalOptima and other CCI plans, this means that funding for IHSS will no longer be included in plan capitation rates. Under CCI, CalOptima administers the IHSS benefit on behalf of more than 19,000 Medi-Cal, OneCare Connect and OneCare members, and CalOptima is responsible for passing through the IHSS-related payments to the county. CalOptima's payments to the county are approximately $19 million a month. Though CalOptima will no longer be administering the IHSS benefit, CalOptima's Medi-Cal, OneCare Connect and OneCare members will still have access to IHSS. The only difference is that the benefit will be administered directly by the County of Orange rather than CalOptima.

Since the current structure of CCI will be discontinued on January 1, 2018, new legislation will be required to extend the life of Cal MediConnect and the integration of MLTSS into Medi-Cal managed care plans. As such, DHCS will draft relevant trailer bill language for inclusion in the FY 2017–18 budget. Staff will remain engaged in the legislative process and monitor developments in the state budget subcommittees related to the continuation of Cal MediConnect.

CHIP Reauthorization

The budget proposal addresses one potential change at the federal level with respect to reauthorization of CHIP, which is currently set to expire on September 30, 2017. As of 2014, 36 million children nationally are covered under CHIP, which was known as the Healthy Families Program in California before its integration into Medi-Cal in 2013.[1] California's federal match for CHIP-related funding is currently 88 percent, which includes a 23 percent increase authorized under the terms of the Affordable Care Act (ACA). The budget proposal assumes that CHIP will be reauthorized, but that the enhanced ACA match will not be continued and the state's federal match will revert to 65 percent. Consequently, the budget allocates $536.1 million General Fund to cover this anticipated reduction in federal funding. CalOptima has approximately 110,000 Medi-Cal/CHIP children. The funding for their coverage is not likely to be affected given the proposed budget's allocation of General Fund dollars to account for the anticipated shortfall in federal funding.

Implementation Delays

In conjunction with the release of the state budget proposal, the Department of Health Care Services (DHCS) announced later start dates for several initiatives, including the transition of California Children's Services (CCS) to the Whole Child Model in certain COHS counties, the transition of the Multipurpose Senior Services Program (MSSP) waiver into managed care, the launch of Alternative Payment Methodology (APM) pilots for Federally Qualified Health Centers (FQHCs), and the effective date of the Medi-Cal managed care palliative care program authorized under Senate Bill 1004 (2014).

CCS Transition (SB 586)

The Whole Child Model will transition CCS into managed care in select COHS counties. Senate Bill (SB) 586 (Chapter 625, Statutes of 2016) effectuated this change, and CalOptima has been preparing for this transition for more than two years. The CCS program provides financial assistance, medical case management, as well as physical and occupational therapy services for approximately 180,000 medically fragile children statewide. As part of the Whole Child Model, CalOptima will be responsible for providing most CCS services to approximately 12,000 members. Many of the CCS services currently administered by the Orange County Health Care Agency (HCA) will transition to CalOptima, such as care coordination, case management, service authorizations and provider referrals. The implementation date of CalOptima's transition plan will be delayed to no sooner than January 1, 2019.

Multipurpose Senior Services Program (MSSP)

As an alternative to nursing facility placement, MSSP provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older and disabled. Authorized under a 1915(c) Home and Community-Based Services waiver, MSSP allows these individuals to remain safely in their homes while receiving social and health management services. Since MSSP currently operates under the authority of a waiver, its continuation is contingent upon the continued operation of the 1915(c) waiver. DHCS had suggested including MSSP as part of the regular schedule of Medi-Cal benefits, thus, giving the program greater stability. However, DHCS, in conjunction with Departments of Social Services and

[1] "Annual Enrollment Reports," Centers for Medicare and Medicaid Services, https://www.medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

Aging, proposes to further delay full transition of the MSSP waiver into managed care for another two years. In Orange County, CalOptima will continue to provide MSSP services to eligible seniors under the current waiver authority.

Federally Qualified Health Centers (FQHCs) APM Pilots (SB 147)
FQHCs are community-based organizations that offer primary care to people of all ages, regardless of their ability to pay or health insurance status. FQHCs currently receive reimbursement for services via 1) Health plan payments, 2) Wraparound payment, and 3) Reconciliation adjustment. SB 147 (Chapter 760, Statutes of 2015) established a three-year FQHC Alternative Payment Model (APM) Pilot program. Under the APM, participating FQHCs would receive monthly capitation payments from health plans instead of the three different types of payments currently received. There are several FQHCs in Orange County interested in participating in the pilot, and CalOptima has been engaged in the planning and implementation process. Per the Governor's 2017–18 budget proposal, the implementation of the FQHC APM Pilot will be delayed from October 2017 to no sooner than January 2018.

Palliative Care (SB 1004)
Palliative Care involves the treatment of mental and physical pain without curing the underlying condition, especially for patients suffering from terminal illnesses. SB 1004 (Chapter 574, Statutes of 2014) requires DHCS to establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services. Palliative care strategies include advance care planning, pain and symptom management, and palliative care consultations, among other services. DHCS proposes to delay the implementation of this program from April 2017 to no sooner than July 2018.

Timeline Summary

- CCS Whole Child Model implementation: *No sooner than January 1, 2019*
- FQHC Alternative Payment Methodology Pilot: *No sooner than January 1, 2018*
- Palliative care program (SB 1004): *No sooner than July 1, 2018*

Next Steps

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

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