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

THURSDAY, APRIL 13, 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 March 9, 2017 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

A. Consider Approval of FY 2017-18 PAC Meeting Schedule
B. Consider Approval of FY 2016-17 PAC Accomplishments
C. Consider Approval of FY 2017-18 PAC Goals and Objectives

VI. CEO AND MANAGEMENT REPORTS

A. Chief Executive Officer (CEO) Update
B. Chief Operating Officer (COO) Update
C. Chief Medical Officer (CMO) Update
D. Chief Financial Officer (CFO) Update

VII. INFORMATION ITEMS

A. Federal and State Legislative Update
B. Opioid Epidemic Update
C. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

MINUTES

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

March 9, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, March 9, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:10 a.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Anjan Batra, M.D.; Donald Bruhns; Stephen N. Flood; Jena Jensen; Pamela Kahn, R.N.; 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:	Theodore Caliendo, M.D.; Alan Edwards, M.D.; George Orras, Ph.D., FAAP
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Helmer, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the PAC

MINUTES

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

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the February 9, 2017 meeting. (Motion carried 12-0-0; Members Caliendo, Edwards, 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, discussed the ongoing Affordable Care Act (ACA) changes related to Medicaid Classic and Medicaid Expansion (MCE). Under the current plan, the Medicaid Classic 50/50 split of federal and state funding would continue until January 1, 2020, at which time a target-spending threshold for each state would be developed and if the states exceed that threshold, there would be funding cuts initiated for the next year for that particular state. Mr. Schrader also noted that the MCE would continue enhanced funding for providers through January 1, 2020. Federal funding for members enrolled in MCE after January 1, 2020 will be provided at up to 50%. Mr. Schrader also updated the PAC on his recent meetings with the Orange County delegation in Washington D.C. regarding the importance of ensuring appropriate funding for CalOptima's programs

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, provided an update on the Magellan transition of the behavioral health benefit. Dr. Helmer noted that CalOptima has limited Intergovernmental Transfer (IGT) funds allocated to screen adolescents for depression. There was extended discussion about how to best rollout this program to CalOptima providers.

Dr. Helmer also discussed the challenge of coordinating care for the homeless and the homeless with mental health issues without duplicating services. Tracy Hitzeman, Executive Director, Clinical Operations, noted that CalOptima holds semi-annual community resource fairs with community-based organizations that offer various resources for members. The target audiences for these resource fairs are case managers and personal care coordinators from the health networks. After extended discussions, Chair Miranti indicated that she was forming a PAC ad hoc committee for the specific purpose of identifying services that are available for the homeless, and to return to the PAC with its findings and recommendations. Members Flood and Nishimoto agreed to serve with Chair Miranti on this ad hoc.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, noted that the CalOptima Community Network (CCN) had reached membership capacity for the last three (3) months and will no longer be eligible for auto-assignment. Ms. Khamseh noted that each member still had the option to choose his or her own network, including the CCN.

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 replacement of the Affordable Care Act (ACA) and the American Health Care Act (AHCA) proposed by the Trump Administration. Mr. Tsunoda noted that Congress had not yet asked the Congressional Budget Office (CBO) to review the proposed legislation. However,, this is expected to occur within the next few days.

Whole Person Care Pilot Update

Melissa Tober of the Orange County Healthcare Agency provided an update on the status of the Whole Person Care (WPC) Pilot Proposal. Ms. Tober noted that the target populations for this pilot are persons who are homeless and persons who are homeless and living with mental illness.

PAC Member Updates

Chair Miranti asked the Members to review the draft 2017-18 PAC Goals and Objectives. PAC members expressed support for the idea of holding a joint Member Advisory Committee (MAC)/PAC meeting in September. If MAC agrees to a joint meeting, a MAC/PAC ad hoc would be formed to discuss possible agenda items of mutual interest to the committees.

Chair Miranti reminded the members to provide input on the PAC Report to the Board to staff for inclusion in the next report. She also reminded the members that applications/nominations are being accepted from March 1, 2017 through March 31, 2017 for the Community Health Centers, Hospital, Physician and Traditional/Safety Net Representative seats on the PAC, as well as nominations for PAC Chair and Vice Chair for the coming year. Chair Miranti formed a Nomination ad hoc and Members Pham, Batra and Bruhns agreed to serve. Candidate recommendations will be considered at the May PAC meeting.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:26 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: April 13, 2017

MEMORANDUM

DATE:	April 6, 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

American Health Care Act (AHCA)
On March 24, the AHCA was pulled from U.S. House of Representatives due to lack of support. While House Speaker Paul Ryan indicated that the GOP is "moving on" from health care, we will stay engaged with our associations, federal advocate and congressional delegation regarding possible future action to change the Affordable Care Act generally and Medicaid Expansion specifically. We also plan to closely monitor any regulatory or policy changes from the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) that may occur in lieu of legislative actions. Separately, before the reversal on AHCA, the California Department of Health Care Services (DHCS) released an analysis of the bill, identifying five serious concerns about the "massive and significant fiscal shift from the federal government to states." The state's preliminary analysis of the AHCA showed nearly $6 billion in costs to California in 2020, growing to $24.3 billion in 2027.

New Executives
CalOptima welcomed two new executives on March 27. Sesha Mudunuri is Executive Director of Operations. Most recently, he was corporate vice president of claims administration, information technology and analytics for New Directions Behavioral Health in Kansas City, Mo. Prior to that, Mudunuri worked in operations or information services for Kaiser Permanente, Excellus BlueCross BlueShield, Prudential Financial and other organizations. Michelle Laughlin is Executive Director of Network Operations. Most recently, she was senior account director, managed care, for Laboratory Corp. of America's Specialty Testing Division. Laughlin has held several other leadership roles in managed care and provider relations, including at Genzyme Corp., Axiom Health Alliance and Tower Health Plan.

Program of All-Inclusive Care for the Elderly (PACE)
In response to your Board's request at the March meeting, staff and invited experts will present a PACE study session as part of the May 4 Board meeting.

Supervisor Steel Orientation
Orange County Second District Supervisor Michelle Steel is CalOptima's newly appointed alternate Board member. She attended an orientation session on March 21 covering the agency's programs, financials and key issues in 2017 and beyond. Supervisor Steel also received

information regarding the Brown Act, Board member responsibilities and public agency requirements.

CalOptima Community Network (CCN)
CalOptima continuously manages our delivery system, including CCN, CalOptima's direct network. In establishing CCN, your Board set criteria to ensure the fair distribution of members to our network and to private-sector health networks during the auto assignment process. Per the Board's directive when CCN was established, once CCN membership grew to 10 percent of overall CalOptima membership and stayed at that level for three consecutive months, auto assignment to CCN would stop. CCN has met that threshold, with total membership of more than 68,000, so effective April 1, auto assignment to CCN ceased. Importantly, this does not impact a member's ability to choose CCN as their health network nor does this apply to members with certain complex medical conditions who are required to be in CCN Complex. The policies governing CCN auto assignment are at the discretion of your Board, and I understand there may be interest in revisiting the cap. As you know, there are differing perspectives in the community regarding CCN, and performance data and stakeholder input would support your Board in making an informed decision. At the request of our private-sector health networks, staff is developing a side-by-side comparison of CCN to the private-sector health networks. The comparison will include metrics related to financial performance, quality of care, member satisfaction and audit results. CalOptima staff plans to share the comparison data with the Member Advisory Committee and Provider Advisory Committee, your Board's Quality Assurance Committee and Finance and Audit Committee, as well as the CEOs of the health networks, before bringing it to your full Board later this year.

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)
In December, your Board authorized analysis by actuary Milliman Inc. to determine whether the conversion of OneCare from a Dual Eligible Special Needs Plan (D-SNP) to a FIDE-SNP presented a financial advantage based on the frailty index. Milliman studied the issue and provided analysis that showed relatively little financial gain (1 percent increase in revenue). Therefore, CalOptima OneCare will remain a D-SNP at this time, and we plan to submit our 2018 bid as such. If conditions change, we may consider the FIDE-SNP option again in the future and return to the Board with further recommendations.

Health Homes Program
On March 29, DHCS released a revised schedule for implementing the Health Homes Program, reflecting a one-year delay. The first phase will now begin July 1, 2018, with Orange County as part of the second phase, starting January 1, 2019. Federal approval of the program is still pending. As background, the Health Homes Program aims at coordinating the full range of medical, behavioral and community-based services for people with chronic conditions who meet certain eligibility criteria.

Key Meetings
- **UC Health**
  On February 24, I attended a second meeting with UC Health officials to further discuss development of a systemwide agreement for Medi-Cal among the UCs in Southern

California. Led by the executive vice president of UC Health, the meeting included CEOs from L.A. Care Health Plan and Inland Empire Health Plan. While discussions are still at a very preliminary stage, an essential element of any such arrangement will be differentiating payment for UC's routine, community-based primary care and hospital services vs. advanced, highly specialized tertiary and quaternary care. Ultimately, if an agreement is reached, CalOptima members could gain more access to tertiary and quaternary care from UC medical centers and affiliates. I will keep your Board informed about progress and next steps.

- **ACAP Meetings**
  The Association for Community Affiliated Plans (ACAP) Annual Conference was held March 20–23 in Costa Mesa, and CalOptima played a leading role since the event was in our county. Our executive team participated in or led three different sessions. Tracy Hitzeman, Executive Director of Clinical Operations, and Caryn Ireland, Executive Director of Quality and Analytics, spoke about Medicare Star ratings and quality measures. I provided an update on Cal MediConnect and OneCare Connect. In addition, Interim CFO Nancy Huang was on a panel to discuss the role of the CFO in achieving the Triple Aim. Separately, we also welcomed ACAP execs to our offices for a meeting and to the PACE center for a tour.

Provider Advisory Committee
FY 2017-2018 Meeting Schedule

July
Thursday, July 13, 2017
No Meeting

August
Thursday, August 10, 2017

September
Thursday, September 14, 2017*

October
Thursday, October 12, 2017

November
Thursday, November 9, 2017

December
Thursday, December 14, 2017

January
Thursday, January 11, 2018
No Meeting

February
Thursday, February 8, 2018

March
Thursday, March 8, 2018

April
Thursday, April 12, 2018

May
Thursday, May 10, 2018

June
Thursday, June 14, 2018

Regular Meeting Location and Time
CalOptima
www.caloptima.org
505 City Parkway West, 1st Floor
Orange, CA 92868
Conference Room 109-N
8:00 a.m. – 10:00 a.m.

***Joint MAC/PAC Meeting**
All meetings are open to the public. Interested parties are encouraged to attend.

Provider Advisory Committee
FY 2016 - 2017 Accomplishments

During FY 2016-2017 the Provider Advisory Committee (PAC) of the CalOptima Board of Directors provided input on provider issues to ensure that CalOptima members continue to receive high quality health care services. The following list highlights their accomplishments:

- PAC CAHPS Ad Hoc Committee made up from representatives from the Community Health Centers, Health Networks, Pharmacy, Physician and the Non-Physician Medical Practitioner held five meetings to provide feedback and advice to CalOptima staff towards training, education and upcoming focus groups for the next 2017 CAHPS survey, with mutual goals to increase scores.

- The PAC Community Clinic Representative participated in two safety net meetings with CalOptima Board members who represent clinics and CalOptima leadership. The discussion focused on ways CalOptima can partner with the safety net in Orange County. The representative also co-chaired the OC Health Improvement Partnership in 2016.

- PAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2016–2017.

- One of the three PAC Physician Representatives (Dr. Sweidan) served on the CalOptima's Quality Improvement Committee (QIC): this committee provides overall direction for the continuous improvement process and oversees activities that are consistent with CalOptima's strategic goals and priorities; promotes an interdisciplinary approach to driving continuous improvement and makes certain that adequate resources are committed to the program; supports compliance with regulatory and licensing requirements and accreditation standards related to quality improvement projects, activities and initiatives; also monitors and evaluates the care and services members are provided to promote quality of care.

- One of the two PAC LTSS Representatives provided input and assisted CalOptima staff to create electronic remittance advice implementation.

- PAC LTSS Representative continues to participate in the Long Term Services and Supports Quality Subcommittee (LTSS QISC). His role is to provide input in CalOptima LTSS Quality Program. This has resulted in improvements to the quality metrics used to measure LTSS providers and the educational programs used to improve knowledge and services at the provider level.

- All PAC members completed the annual Compliance Training for 2016/17 by the deadline.

- 2017 PAC Nomination Ad Hoc subcommittee met on April 24, 2017, to select new PAC members for the four PAC vacancies: Community Health Centers; Hospital; Physician and Traditional/ plus the PAC Chair and Vice Chair for FY 2017-18. Three ad hoc members presented the slate of candidates to the full PAC on May 11, 2017 with their recommendations.

- PAC members supported the intergovernmental transfer (IGT) projects that are completed or in progress, as well as the proposed recommendations for the use of the remaining IGT funds.

- The PAC Chair or Vice Chair submitted and presented the PAC Report at CalOptima's Board of Directors' monthly meetings to provide the Board with input and updates on the PAC's current activities.

- PAC members attendance equals on average over 81% of members attend each monthly meeting and there are 11 out of 15 members attending each meeting.

- In addition to meeting on a monthly basis over the course of the FY 2016-17, PAC members have participated in at least eight (8) ad hoc subcommittees and dedicated approximately 331 hours or the equivalent of 41 business days. This does not account for the time spent preparing for meetings, reviewing reports, participating in their professional associations and communicating with CalOptima staff and their respective constituencies.

- Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities during the monthly Board Meetings. In addition, the PAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

CalOptima Board of Directors'
Provider Advisory Committee
Goals and Objectives
FY 2017/18

GOALS AND OBJECTIVES FY 2017-18

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	**1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set a goal to improve HEDIS performance metrics. PAC Members to discuss ideas collected from their constituencies to develop a plan to reach the goal. 3) Coordinating data from the community and CalOptima using CalOptima's data warehouse.
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	1) Monitor access and coordination of behavioral health and medical services through regular updates from CalOptima and Magellan. 2) Continue Whole Person Care Model updates.
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	PAC will provide input into IGT funding recommendations prior to board approval.
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	**1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.**	PAC Members to identify three (3) burdensome administrative pain points to improve efficiencies and work with CalOptima Staff to address these.

CalOptima Board of Directors'
Provider Advisory Committee
Goals and Objectives
FY 2017/18

GOALS AND OBJECTIVES FY 2017-18

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities
II. Value (Cont.)	**Maximize the value of care for members by ensuring quality in a cost effective way (Cont.)**	**2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set a goal to improve HEDIS performance metrics. PAC Members to discuss ideas collected from their constituencies to develop a plan to reach 3) Coordinating data from community and CalOptima using CalOptima's data warehouse.
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	Explore ideas to broaden access for hard to find providers.
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	**1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to imprve service to providers and members, expand access, and advance shared health priorities.**	Provide timely input on key issues prior to Board decision.
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	Hold a joint MAC/PAC Meeting once a year to share information if MAC is agreeable.

CalOptima Board of Directors'
Provider Advisory Committee
Goals and Objectives
FY 2017/18

GOALS AND OBJECTIVES FY 2017-18

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities
III. Partnership and Engagement (Cont.)	**Engage providers and community partners in improving the health status and experience of our members (Cont.)**	**3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.**	Review quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers
		4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.	Support Board and CalOptima to proactively respond to ACA, OCC and Cal MediConnect changes.

Charge of the Advisory Committees pursuant to Resolution No. 2-14-95:

1. Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board.
2. Engage in study, research and analysis on issues assigned by the Board or generated by the committees.
3. Serve as liaisons between interested parties and the Board.
4. Assist the Board in obtaining public opinion on issues related to CalOptima.
5. Initiate recommendations on issues of study to the Board for their approval and consideration.
6. Facilitate community outreach for CalOptima and the CalOptima Board.

Opioid Update

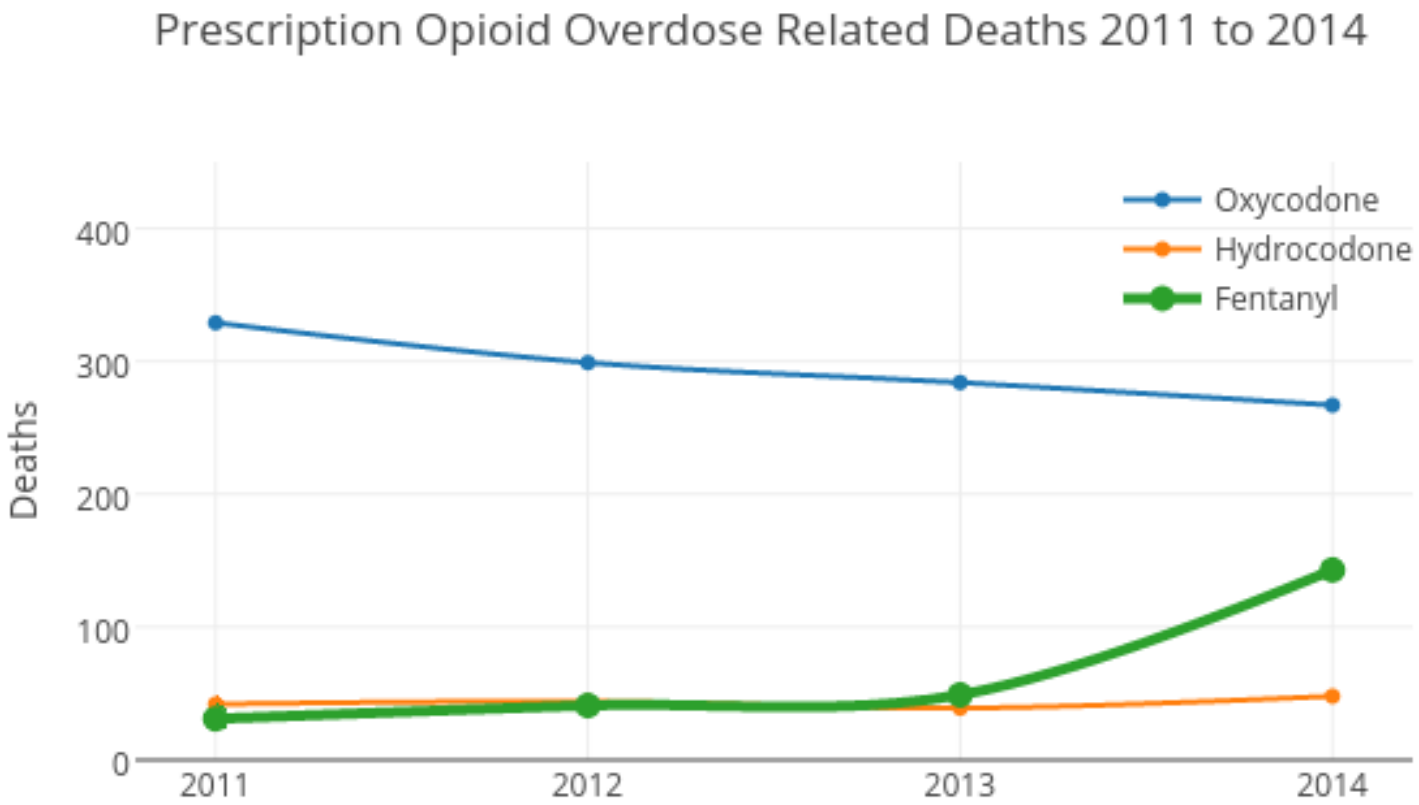
Provider Advisory Committee

April 13, 2017

Richard Bock, M.D.

Deputy Chief Medical Officer

Changing Face of Opioid Epidemic



Changing Face of Opioid Epidemic

- Prescriptions for OxyContin have fallen nearly 40 percent since 2010, meaning billions in lost revenue for its Connecticut manufacturer, Purdue Pharmaceuticals

- Taking a page from Big Tobacco, OxyContin goes global
  - "We're only just getting started."

- A network of international companies owned by the family is moving rapidly into Latin America, Asia, the Middle East, Africa and other regions, and pushing for broad use of painkillers

Changing Face (Cont.)

- Fentanyl-related overdoses prompt CDC alert
  - Wall Street Journal Headline: *"Trial Reveals Deep Ties Between Pair of Doctors and Fentanyl Maker: Prosecutors allege two doctors made $40 million in illicit profit"*
- DEA issues nationwide warning on Carfentanil
  - Animal opioid sedative, 10,000 times stronger than morphine
- Fentanyl and Carfentanil have been mixed with powder heroin and substituted for pill ingredients
- Combined Benzodiazepine use was associated with 30.1 percent of opioid overdose deaths
- Opioid use was associated with 77.2 percent of benzodiazepine overdose deaths

National Actions to Address Epidemic

- **New Jersey**: Mandated coverage for treatment (6 month in and outpatient)
  - A 5-day cap on the first opioid prescription
  - Opioid education requirements for every licensed health care professional
- **Ohio**: Physicians and dentists can only prescribe up to 50 mg morphine equivalent dose (MED) per day and no more than a 3-day supply
- **California**: Proposal to impose a tax on opioids to fund prevention and rehabilitation services; prohibit opioid prescriptions to minors

National Actions (Cont.)

- **Massachusetts**: Mandatory Prescription Monitoring Program (PMP) database; schools must annually conduct verbal substance misuse screenings; and increased use of specialty drug courts
- **New York**: Requires mandatory prescriber education; no prior authorization allowed for inpatient treatment
- **Repeal and Replace**: Beginning in 2020, the plan would eliminate an Affordable Care Act requirement that Medicaid cover basic mental health and addiction services in states that expanded it

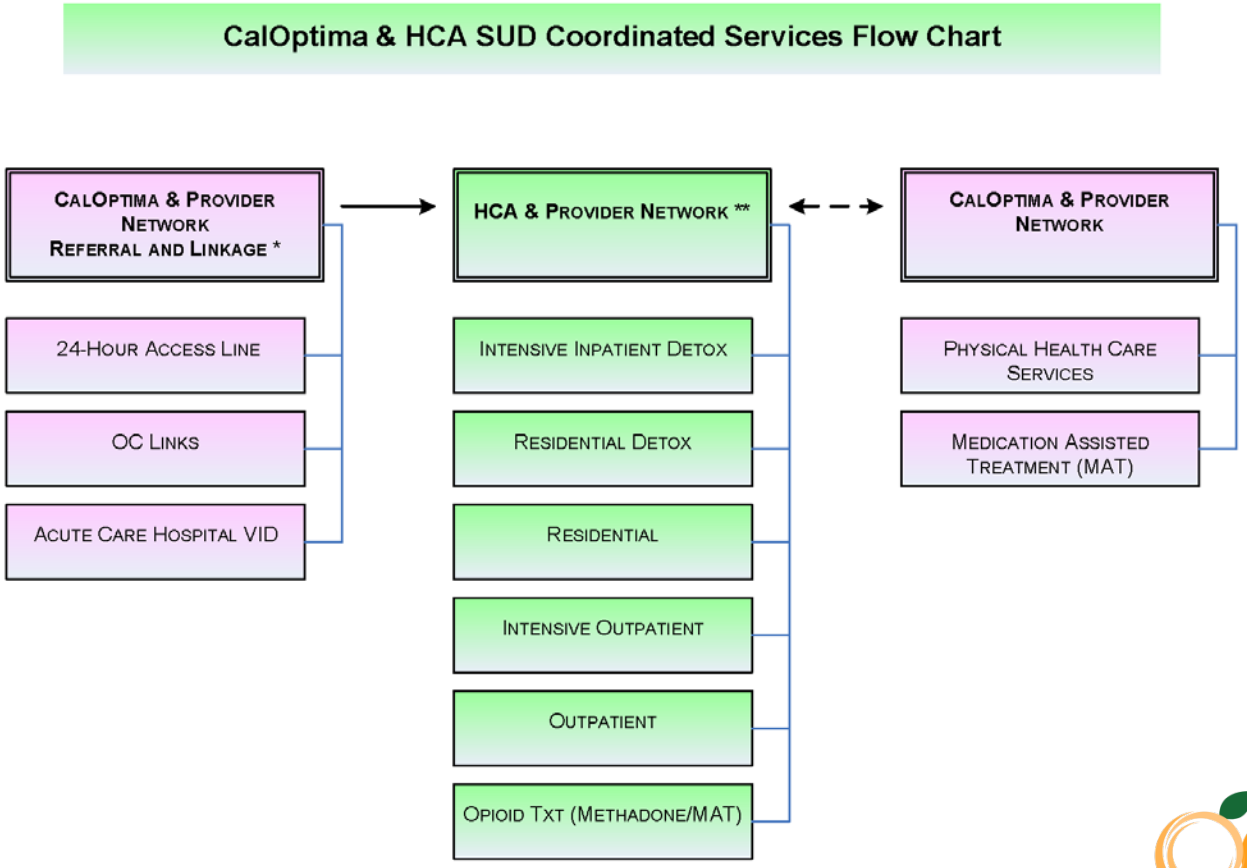
National Actions (Cont.)

- Trump convenes opioid abuse panel with Christie at helm

Opioid Use Disorder Treatment

- Medication-assisted treatment, e.g., Buprenorphine (Suboxone)
  - Stabilizes neurochemical imbalances
  - Relieves symptoms of abstinence syndromes
  - Prevents intoxication and overdose
  - Reduces benzodiazepines
- Overdose rescue — Naloxone
- No wrong door for starting treatment of opioid agonist
- Wellness model with treatment for stable patients located at medical home
- Behavioral restructuring
- Integrated care for needle-related chronic illness, such as HIV and Hepatitis C

CalOptima and HCA SUD Coordinated Services



** Based Upon Screening, Brief Interventions, Referral to Tx (SBIRT)*

**Case Management, Physician Consultation and Recovery Support Services are available in all program*

OC health CARE AGENCY

CalOptima A Public Agency Better. Together.

CalOptima Interventions – I

- **Formulary restrictions January 1, 2017**
  - Cumulative morphine equivalent dose (MED) pharmacy edits (Part D)
  - Restrictions for drugs with the highest risk of overdose
    - Methadone
    - Extended-release opioids
    - Concurrent use of opioids and buprenorphine pharmacy edits

CalOptima Interventions – II

- **Member restriction programs**
  - Pharmacy Home Program Policy (1,022 members enrolled)
  - Prescriber Restriction Program Policy (364 eligible Medi-Cal members, 40 enrolled)
  - Part D opioid overutilization monitoring and case management (60 member interventions)
  - Fraud and abuse referrals to Compliance (176 members)

CalOptima Interventions – III

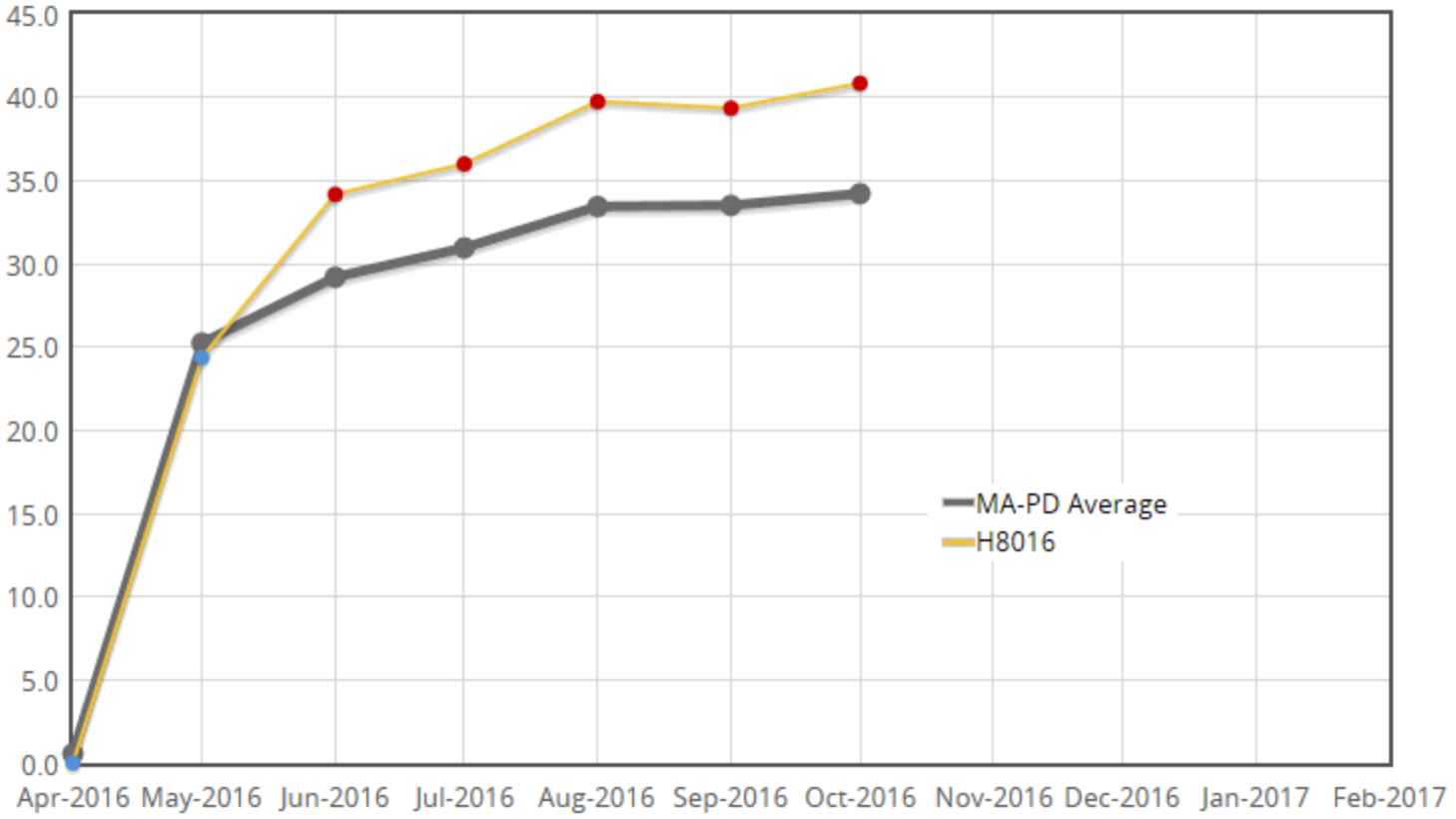
- **Prescriber outreach programs**
  - Opioid-containing cough medicines
    - 177 resident reviews
    - 101 discontinued
  - Highest MED prescribers
    - 15 prescribers, 177 high-dose Rx
    - 237 concomitant benzodiazepines
  - High volume/high MED prescribers
    - Top 5 percent sent scorecards (December 2016)

CalOptima Interventions – IV

- **Quality measures**
  - Retrospective review of opioid overutilization by medical director
    - 120 members referred to Compliance and/or Case Management
  - ACAP plan opioid utilization benchmarking study (on legal hold)
  - Pharmacy Quality Alliance (PQA) Part D Star display measures
    - High dosage
    - Multiple providers

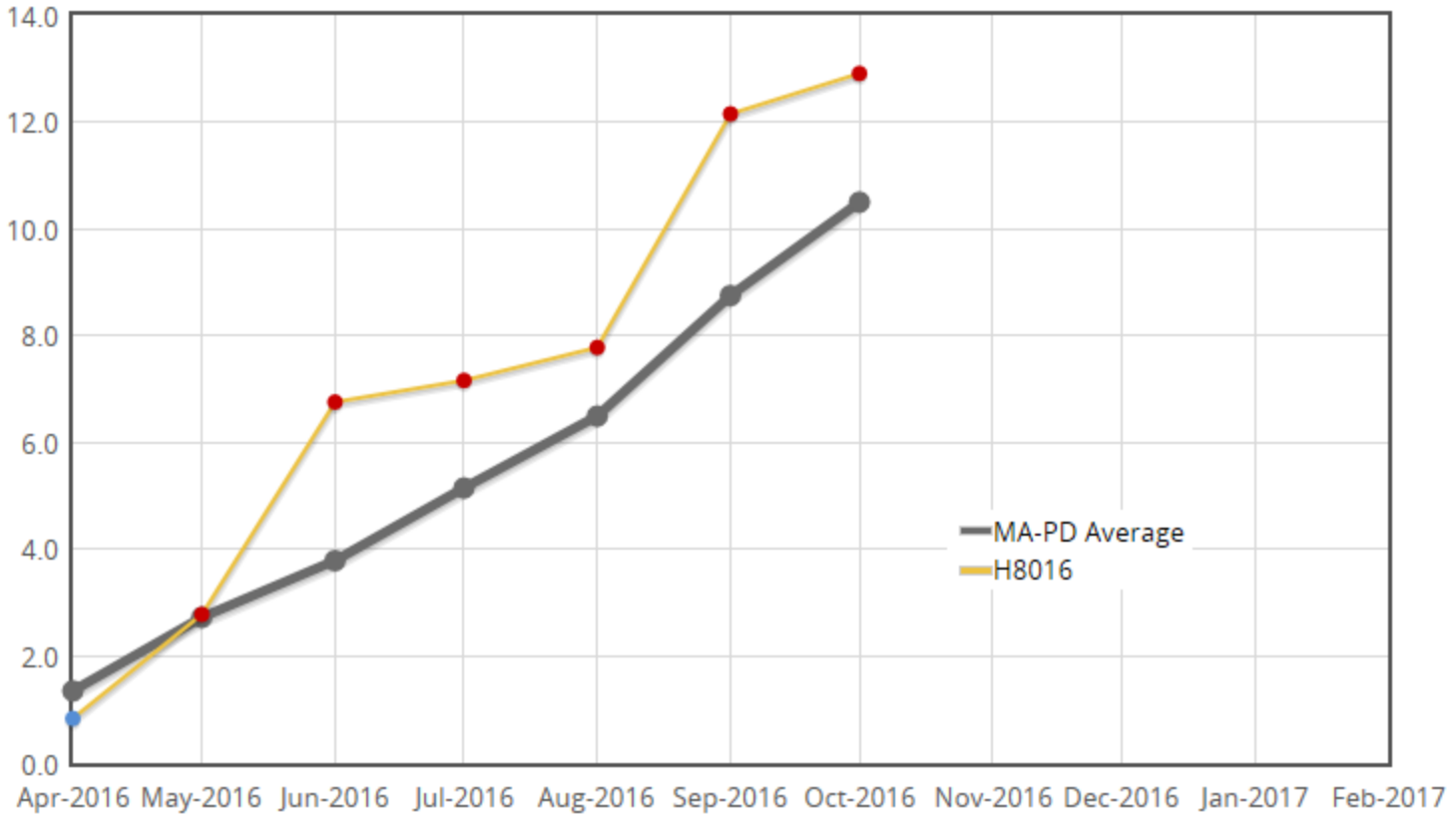
OneCare Connect Part D Report Card – Display

Opioid – High Dosage Measure Performance



OneCare Connect Part D Report Card – Display

Opioid – Multiple Providers Measure Performance



CalOptima Interventions – V

- **Ongoing CME series for physicians**
  - January 27, 2016

    The State of Opioid Prescribing in Orange County: Practical Strategies and Update on CURES 2.0

    Total attendees: 63
  - July 28, 2016

    The State of Opioid Prescribing in Orange County: Critical Issues in Over-the-Counter (OTC) Analgesia

    Total attendees: 72
  - March 30, 2017

    The State of Opioid Prescribing in Orange County: PCP Treatment Options and Access to Behavioral Health Services
- **Informational Series for the community**
  - March 3, 2017

    Panel: Drs. Khatibi, Bock and Chakravarthy, and Sandra Fair

CalOptima Interventions – VI

- **Coalition participation**
  - ACAP
    - Opioid Intervention (2015) – CalOptima cited as one of 13 Best Practice Plans for Pharmacy Lock-in Program
  - Safe Rx OC
    - Since 2015, CalOptima participating with public health agencies, hospitals, prescribers, community clinics, emergency rooms, medical associations and law enforcement to curb abuse and save lives
  - DHCS Health Homes Program (2018)
    - Care management for those with SUD and eligible chronic conditions

Affiliations and Resources

- NIH: National Institute on Drug Abuse
- Drugabuse.gov
- SAMHSA: Substance Abuse and Mental Health Services Administration
- ACAP: SUD Collaborative
- Cures 2.0
- CHCF: Opioid Safety Coalition Network
- Smart Care California (DHCS, CalPERS, Covered CA)
- California Department of Public Health
  - Prescription Opioid Misuse and Overdose Prevention Workgroup
  - Prescription Drug Overdose Prevention Initiative
  - California Opioid Overdose Surveillance Dashboard

A Public Agency

CalOptima

Better. Together.

Financial Summary

February 2017

Nancy Huang

Interim Chief Financial Officer

FY 2016-17: Consolidated Enrollment

- February 2017 MTD:
  - Overall enrollment was 791,103 member months
    - Actual lower than budget by 14,913 or 1.9%
      - Medi-Cal: unfavorable variance of 9,551 members
        - Lower than budget in TANF aid categories
      - OneCare Connect: unfavorable variance of 5,470 members
    - 0.5% or 4,249 decrease from prior month
      - Medi-Cal: decrease of 4,112 from January
      - OneCare Connect: decrease of 124 from January
      - OneCare: decrease of 23 from January
      - PACE: increase of 10 from January

FY 2016-17: Consolidated Enrollment

- February 2017 YTD:
  - Overall enrollment was 6,378,684 member months
    - Actual lower than budget by 40,606 or 0.6%
      - Medi-Cal: unfavorable variance of 3,658 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 37,108 members or 21.1%
      - PACE: unfavorable variance of 1 members or 0.1%
      - OneCare: favorable variance of 161 members or 1.7%

FY 2016-17: Consolidated Revenues

- February 2017 MTD:
  - Actual lower than budget by $6.8 million or 2.4%
    - Medi-Cal: favorable to budget by $11.7 million or 5.0%
      - Price related favorable variance of $14.6 million due to:
        - $4.8 million of LTC revenue for non-LTC members
        - $4.2 million for IHSS
        - Remaining from member mix difference versus budget
      - Volume related unfavorable variance of $2.9 million
    - OneCare Connect: unfavorable variance of $18.4 million or 42.3%
      - Unfavorable volume variance of $11.0 million
      - Unfavorable price variance of $7.4 million
        - OCC Medicare Part A and B revenue decreases due to base rate and RAF score changes
        - OCC Medi-Cal adjustments related to prior year updates.
        - OCC Medi-Cal cohorts mix true-up for prior periods

FY 2016-17: Consolidated Revenues (con't.)

- February 2017 YTD:
  - ➢ Actual lower than budget by $31.7 million or 1.4%
    - Medi-Cal: favorable to budget by $88.1 million or 4.7%
    - OneCare Connect: unfavorable variance of $120.2 million or 33.4%
      - Medi-Cal revenue unfavorable $40.4 million
      - Medicare revenue unfavorable $79.8 million
    - OneCare: unfavorable $0.5 million or 4.4%
    - PACE: favorable $0.9 million

FY 2016-17: Consolidated Medical Expenses

- February 2017 MTD:
  - ➢ Actual higher than budget by $3.1 million or 1.2%
    - ▪ Medi-Cal: unfavorable variance of $18.8 million
      - MLTSS unfavorable variance $14.7 million
        - ➢ LTC unfavorable variance $14.7 million
          - $6.9 million higher LTC Claim expense due to less than anticipated members enrolling in OneCare Connect
          - $2.0 million variance from FY17 mandated rate accrual
        - ➢ IHSS related unfavorable variance approximately $5.4 million
      - Provider Capitation unfavorable variance of $12.9 million related to one additional HMO network beginning in February
      - Facilities expenses favorable variance of $7.0 million due to one shared risk group network moving to HMO model in February
    - ▪ OneCare Connect: favorable variance of $15.6 million
      - Favorable volume variance of $10.3 million
      - Favorable price variance of $5.3 million
        - ➢ Lower than budget prescription drugs and LTC costs

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

- February 2017 YTD:
  - Actual lower than budget by $1.0 million
    - Medi-Cal: unfavorable variance of $107.6 million
      - Unfavorable price variance of $108.7 million
        - IHSS estimated expense $42.7 million higher than budget
        - Long Term Care expense $40.8 million higher than budget
        - Facilities expense $10.6 million higher than budget
      - Favorable volume variance of $1.0 million
    - OneCare Connect: favorable variance of $107.2 million
      - Favorable volume variance of $71.4 million
      - Favorable price variance of $35.8 million

- Medical Loss Ratio (MLR):
  - February 2017 MTD: Actual: 96.0% Budget: 92.6%
  - February 2017 YTD: Actual: 96.7% Budget: 95.4%

FY 2016-17: Consolidated Administrative Expenses

- February 2017 MTD:
  - Actual lower than budget by $2.1 million or 18.5%
    - Salaries and Benefits: favorable variance of $1.3 million
    - Other categories: favorable variance of $0.8 million
- February 2017 YTD:
  - Actual lower than budget by $19.0 million or 20.4%
    - Salaries and Benefits: favorable variance of $12.8 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $6.1 million

- Administrative Loss Ratio (ALR):
  - February 2017 MTD: Actual: 3.4% Budget: 4.1%
  - February 2017 YTD: Actual: 3.3% Budget: 4.1%

FY 2016-17: Change in Net Assets

- February 2017 MTD:
  - $3.7 million surplus
  - $5.8 million unfavorable to budget
    - Lower than budgeted revenue of $6.8 million
    - Lower than budgeted administrative expenses of $2.1 million
    - Higher than budgeted medical expenses of $3.1 million
    - Higher than budgeted investment income of $2.0 million

- February 2017 YTD:
  - $7.1 million surplus
  - $5.4 million unfavorable to budget
    - Lower than budgeted revenue of $31.7 million
    - Lower than budgeted medical expenses of $1.0 million
    - Lower than budgeted administrative expenses of $19.0 million
    - Higher than budgeted investment income of $5.9 million

Enrollment Summary: February 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
59,819	55,872	3,947	7.1%	Aged	468,234	442,521	25,713	5.8%
618	679	(61)	(9.0%)	BCCTP	4,975	5,415	(440)	(8.1%)
48,693	47,325	1,368	2.9%	*Disabled*	388,478	379,454	9,024	2.4%
327,943	343,267	(15,324)	(4.5%)	TANF Child	2,667,305	2,724,654	(57,349)	(2.1%)
98,357	108,884	(10,527)	(9.7%)	TANF Adult	814,218	875,411	(61,193)	(7.0%)
3,257	2,726	531	19.5%	LTC	26,101	21,581	4,520	20.9%
234,719	224,204	10,515	4.7%	MCE	1,859,408	1,783,341	76,067	4.3%
773,406	**782,957**	**(9,551)**	**(1.2%)**	**Medi-Cal**	**6,228,719**	**6,232,377**	**(3,658)**	**(0.1%)**
16,222	**21,692**	**(5,470)**	**(25.2%)**	**OneCare Connect**	**138,671**	**175,779**	**(37,108)**	**(21.1%)**
194	**200**	**(6)**	**(3.0%)**	**PACE**	**1,459**	**1,460**	**(1)**	**(0.1%)**
1,281	**1,167**	**114**	**9.8%**	**OneCare**	**9,835**	**9,674**	**161**	**1.7%**
791,103	**806,016**	**(14,913)**	**(1.9%)**	**CalOptima Total**	**6,378,684**	**6,419,290**	**(40,606)**	**(0.6%)**

Financial Highlights: February 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
791,103	806,016	(14,913)	(1.9%)	Member Months	6,378,684	6,419,290	(40,606)	(0.6%)
275,065,163	281,859,471	(6,794,308)	(2.4%)	Revenues	2,222,592,702	2,254,327,683	(31,734,981)	(1.4%)
264,197,736	261,080,635	(3,117,101)	(1.2%)	Medical Expenses	2,149,134,529	2,150,139,207	1,004,677	0.0%
9,352,941	11,470,815	2,117,874	18.5%	Administrative Expenses	73,831,259	92,790,136	18,958,877	20.4%
1,514,486	**9,308,021**	**(7,793,535)**	**(83.7%)**	**Operating Margin**	**(373,086)**	**11,398,341**	**(11,771,427)**	**(103.3%)**
2,175,714	132,617	2,043,098	1540.6%	Non Operating Income (Loss)	7,490,167	1,124,734	6,365,433	566.0%
3,690,200	**9,440,638**	**(5,750,438)**	**60.9%**	**Change in Net Assets**	**7,117,081**	**12,523,074**	**(5,405,994)**	**(43.2%)**
96.0%	92.6%	(3.4%)		Medical Loss Ratio	96.7%	95.4%	(1.3%)	
3.4%	4.1%	0.7%		Administrative Loss Ratio	3.3%	4.1%	0.8%	
0.6%	3.3%	(2.8%)		Operating Margin Ratio	(0.0%)	0.5%	(0.5%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Consolidated Performance Actual vs. Budget: February 2017 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
3.2	8.8	(5.6)	Medi-Cal	4.3	9.9	(5.6)
(0.1)	0.0	(0.1)	OneCare	(0.3)	0.2	(0.5)
(1.7)	0.6	(2.3)	OCC	(5.2)	3.0	(8.2)
0.0	(0.1)	0.1	PACE	0.7	(1.8)	2.5
1.4	**9.3**	**(7.9)**	**Operating**	**(0.5)**	**11.4**	**(11.9)**
2.3	0.1	2.1	Inv./Rental Inc, MCO tax	7.6	1.1	6.5
2.3	**0.1**	**2.1**	**Non-Operating**	**7.6**	**1.1**	**6.5**
3.7	**9.4**	**(5.8)**	**TOTAL**	**7.1**	**12.5**	**(5.4)**

Consolidated Revenue & Expense: February 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	538,687	234,719	773,406	1,281	16,222	194	791,103
REVENUES							
Capitation Revenue	$ 138,281,268	$ 109,083,952	$ 247,365,220	$ 1,325,118	$ 25,134,734	$ 1,240,091	$ 275,065,163
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	138,281,268	109,083,952	247,365,220	1,325,118	25,134,734	1,240,091	275,065,163
MEDICAL EXPENSES							
Provider Capitation	39,473,179	48,806,830	88,280,009	405,341	8,052,308	-	96,737,659
Facilities	23,632,438	23,464,976	47,097,415	298,893	7,197,011	237,676	54,830,996
Ancillary	-	-	-	11,280	831,025	-	842,306
Skilled Nursing	-	-	-	135,811	-	-	135,811
Professional Claims	7,091,859	8,041,046	15,132,904	-	-	226,458	15,359,362
Prescription Drugs	17,368,544	15,889,723	33,258,267	400,003	1,613,064	90,238	35,361,572
Long-term Care Facility Payments	47,474,400	2,341,069	49,815,469	-	6,378,067	7,327	56,200,863
Medical Management	2,603,881	-	2,603,881	60,680	914,846	404,986	3,984,393
Reinsurance & Other	(642,116)	1,150,896	508,780	4,500	89,568	141,928	744,775
Total Medical Expenses	137,002,185	99,694,540	236,696,726	1,316,509	25,075,889	1,108,613	264,197,736
Medical Loss Ratio	**99.1%**	**91.4%**	**95.7%**	**99.4%**	**99.8%**	**89.4%**	**96.0%**
GROSS MARGIN	**1,279,083**	**9,389,412**	**10,668,494**	**8,609**	**58,845**	**131,478**	**10,867,427**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,304,162	21,174	855,733	91,332	6,272,401
Professional fees			186,049	13,913	-	19,250	219,212
Purchased services			996,926	23,483	159,300	6,238	1,185,948
Printing and Postage			245,448	9,854	26,171	68	281,541
Depreciation and Amortization			342,720	-	-	2,065	344,785
Other expenses			726,256	0	40,295	6,029	772,580
Indirect cost allocation, Occupancy expense			(403,146)	22,850	654,511	2,260	276,475
Total Administrative Expenses			7,398,414	91,274	1,736,010	127,243	9,352,941
Admin Loss Ratio			**3.0%**	**6.9%**	**6.9%**	**10.3%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			3,270,080	(82,664)	(1,677,164)	4,234	1,514,486
INVESTMENT INCOME			-	-	-	-	2,243,095
NET RENTAL INCOME			-	-	-	-	8,315
NET GRANT INCOME			(75,814)	-	-	-	(75,814)
OTHER INCOME			119	-	-	-	119
CHANGE IN NET ASSETS			**$ 3,194,385**	**$ (82,664)**	**$ (1,677,164)**	**$ 4,234**	**$ 3,690,200**
BUDGETED CHANGE IN ASSETS			8,793,252	21,100	613,429	(119,759)	9,440,638
VARIANCE TO BUDGET - FAV (UNFAV)			(5,598,868)	(103,764)	(2,290,593)	123,994	(5,750,438)

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Consolidated Revenue & Expense: February 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	4,369,311	1,859,408	6,228,719	9,835	138,671	1,459	6,378,684
REVENUES							
Capitation Revenue	$ 1,104,769,361	$ 857,257,146	$ 1,962,026,508	$ 10,645,302	$ 239,820,446	$ 10,100,447	$ 2,222,592,702
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,104,769,361	857,257,146	1,962,026,508	10,645,302	239,820,446	10,100,447	2,222,592,702
MEDICAL EXPENSES							
Provider Capitation	265,588,210	344,179,570	609,767,780	3,248,784	58,451,088	-	671,467,652
Facilities	221,087,153	239,503,261	460,590,414	2,561,807	71,367,924	2,049,747	536,569,893
Ancillary	-	-	-	332,542	6,045,806	-	6,378,348
Skilled Nursing	-	-	-	466,932	-	-	466,932
Professional Claims	74,189,149	69,359,217	143,548,366	-	-	1,684,042	145,232,408
Prescription Drugs	144,275,943	132,497,552	276,773,495	3,399,865	39,246,868	675,654	320,095,882
Long-term Care Facility Payments	364,802,673	16,156,082	380,958,754	-	47,339,711	43,380	428,341,845
Medical Management	23,164,940	-	23,164,940	180,543	7,922,288	3,155,993	34,423,764
Reinsurance & Other	(3,688,966)	8,189,275	4,500,309	36,771	734,302	886,424	6,157,805
Total Medical Expenses	1,089,419,101	809,884,957	1,899,304,058	10,227,244	231,107,988	8,495,239	2,149,134,529
Medical Loss Ratio	**98.6%**	**94.5%**	**96.8%**	**96.1%**	**96.4%**	**84.1%**	**96.7%**
GROSS MARGIN	**15,350,261**	**47,372,189**	**62,722,450**	**418,058**	**8,712,458**	**1,605,208**	**73,458,173**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			42,119,125	133,128	6,403,332	736,006	49,391,591
Professional Fees			1,011,226	134,270	316,552	33,805	1,495,853
Purchased services			5,738,413	189,059	1,087,987	34,692	7,050,151
Printing and Postage			1,679,951	69,971	489,813	2,265	2,241,999
Depreciation and Amortization			2,528,986			16,378	2,545,363
Other expenses			7,929,432	2,071	289,669	56,539	8,277,710
Indirect cost allocation, Occupancy expense			(2,695,720)	185,730	5,320,121	18,459	2,828,591
Total Administrative Expenses			58,311,413	714,229	13,907,474	898,143	73,831,259
Admin Loss Ratio			**3.0%**	**6.7%**	**5.8%**	**8.9%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			4,411,037	(296,171)	(5,195,016)	707,065	(373,086)
INVESTMENT INCOME			-	-	-	-	7,564,063
NET RENTAL INCOME			-	-	-	-	41,970
NET GRANT INCOME			(116,712)	-	-	-	(116,712)
OTHER INCOME			847	-	-	-	847
CHANGE IN NET ASSETS			**$ 4,295,170**	**$ (296,171)**	**$ (5,195,016)**	**$ 707,065**	**$ 7,117,081**
BUDGETED CHANGE IN ASSETS			9,939,847	199,975	3,018,682	(1,760,164)	12,523,074
VARIANCE TO BUDGET - FAV (UNFAV)			(5,644,677)	(496,147)	(8,213,698)	2,467,228	(5,405,994)

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Balance Sheet:
As of February 2017

ASSETS		
Current Assets		
Operating Cash		$338,960,313
Catastrophic Reserves		11,371,279
Investments		1,527,088,724
Capitation receivable		317,132,174
Receivables - Other		20,020,278
Prepaid Expenses		12,096,533
Total Current Assets		**2,226,669,301**
Capital Assets	Furniture and equipment	33,303,693
	Leasehold improvements	8,334,007
	505 City Parkway West	49,269,863
		90,907,563
	Less: accumulated depreciation	(35,997,907)
	Capital assets, net	**54,909,656**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	1,999,127
	Long term investments	530,660,511
	Total Board-designated Assets	532,659,637
	Total Other Assets	**532,959,637**
	Deferred outflows of Resources - Pension Contributions	3,787,544
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,819,541,612**

LIABILITIES & FUND BALANCES	
Current Liabilities	
Accounts payable	$29,941,908
Medical claims liability	634,186,444
Accrued payroll liabilities	9,616,865
Deferred revenue	917,826,164
Deferred lease obligations	222,558
Capitation and withholds	517,557,114
Total Current Liabilities	**2,109,351,053**
Other employment benefits liability	29,495,473
Net Pension Liabilities	11,756,286
Long Term Liabilities	100,000
TOTAL LIABILITIES	**2,150,702,812**
Deferred inflows of Resources - Excess Earnings	502,900
Deferred inflows of Resources - changes in Assumptions	1,651,640
Tangible net equity (TNE)	94,660,013
Funds in excess of TNE	572,024,247
Net Assets	**666,684,260**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES	**2,819,541,612**

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Board Designated Reserve and TNE Analysis
As of February 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	145,602,803				
	Tier 1 - Logan Circle	145,347,467				
	Tier 1 - Wells Capital	145,395,335				
Board-designated Reserve		436,345,605	291,461,558	456,942,231	144,884,047	(20,596,626)
TNE Requirement	Tier 2 - Logan Circle	96,314,032	94,660,013	94,660,013	1,654,020	1,654,020
	Consolidated:	**532,659,637**	**386,121,571**	**551,602,244**	**146,538,067**	**(18,942,607)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

HN Enrollment Summary - Medi-Cal

Health Network Name	MARCH 2017	Percentage
CHOC Health Alliance (PHC20)	151,428	19.6%
Monarch Family HealthCare (HMO16)	86,620	11.2%
Arta Western Health Network (SRG66)	72,717	9.4%
CalOptima Community Network (CN)	71,140	9.2%
Family Choice Health Network (PHC21)	47,609	6.1%
Kaiser Permanente (HMO04)	45,443	5.9%
Alta Med Health Services (SRG69)	42,300	5.5%
United Care Medical Network (SRG67)	35,091	4.5%
Prospect Medical Group (SRG63)	33,600	4.3%
Noble Mid-Orange County (SRG64)	31,975	4.1%
Talbert Medical Group (SRG65)	24,400	3.2%
AMVI Care Health Network (PHC58)	21,842	2.8%
Heritage - Regal Medical Group (HMO15)	4,316	0.6%
OC Advantage (PHC35)	1,162	0.2%
Total Health Network Capitated Enrollment	**669,644**	**86.5%**
CalOptima Direct (all others)	104,576	13.5%
Total Medi-Cal Enrollment	**774,219**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	MARCH 2017	Percentage
Monarch HealthCare (PMG53DE)	678	53.0%
AMVI/Prospect Medical Group (PMG27DE)	304	23.8%
Talbert Medical Group (PMG52DE)	109	8.5%
Family Choice Medical Group (PMG21DE)	78	6.1%
Arta Western Health Network (PMG66DE)	43	3.4%
Alta-Med (PMG69DE)	34	2.7%
United Care Medical Group (PMG67DE)	25	2.0%
Noble Mid Orange County (PMG64DE)	9	0.7%
Total OneCare Enrollment	**1,280**	**100.0%**

HN Enrollment Summary – OneCare Connect

Health Network Name	MARCH 2017	Percentage
Monarch HealthCare (HMO16DE)	5,130	31.5%
Propect Medical Group (SRG63DB)	3,123	19.2%
Family Choice Medical Group (SRG81DB)	1,921	11.8%
CalOptima Community Network (CN)	1,768	10.9%
Talbert Medical Group (SRG52DB)	1,210	7.4%
United Care Medical Group (SRG67DB)	597	3.7%
Arta Western Health Network(SRG66DB)	590	3.6%
AMVI Care Health Network (PHC58DB)	569	3.5%
Alta-Med (SRG69DB)	558	3.4%
Noble Mid Orange County (SRG64DB)	444	2.7%
Heritage - Regal Medical Group (HMO15)	237	1.5%
OC Advantage (PHC35DB)	113	0.7%
Total OneCare Connect Enrollment	**16,260**	**100.0%**


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Medi-Cal
A Public Agency
CalOptima
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OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
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2017–18 Legislative Tracking Matrix

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
AB 15 (Maienschein)	This bill would require DHCS to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding. This bill would take effect on January 1, 2018.	**01/19/2017** Referred to Assembly Committee on Health	Watch
AB 340 (Arambula)	This bill would require the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) to include screenings for incidents of trauma that affect a child's mental or physical health. The EPSDT program is a comprehensive, preventive Medi-Cal benefit for children under the age of 21. CalOptima provides most EPSDT services, while the Orange County Health Care Agency (HCA) covers services not covered by CalOptima. Further clarification is needed in the bill to define whether trauma screening is considered a specialty mental health service offered by county mental health plans, or if Medi-Cal managed care plans would be responsible for providing these services.	**02/21/2017** Referred to Assembly Committee on Health	Watch
AB 675 (Ridley-Thomas)	This bill would appropriate $650 million of state General Fund dollars to DHCS in order to allow In-Home Supportive Services (IHSS) to continue as a Medi-Cal managed care benefit. The Coordinated Care Initiative (CCI) contained a "poison pill" that went into effect in January, meaning IHSS will no longer be a Medi-Cal managed care benefit beginning January 1, 2018. As a result, counties will absorb the responsibility of IHSS. This bill aims to retain the IHSS provision of CCI by shifting dollars from the General Fund to DHCS.	**03/02/2017** Referred to Assembly Committees on Health and Human Services	Watch
SB 152 (Hernandez)	Based on the most recent guidance from DHCS, CalOptima will implement the Whole Child Model (WCM) no sooner than January 1, 2019. However, under current law, DHCS is required to submit a report to the Legislature no later than January 1, 2021 (two years after plan implementation). Since the WCM implementation date has been delayed, this bill has been introduced to allow plans the full three years to implement the WCM before DHCS submits its report to the Legislature.	**03/23/2017** Referred to Senate Committee on Rules	Watch
SB 171 (Hernandez)	This bill would lengthen the amount of time that Medi-Cal members have to request a state fair hearing. Under current law, if a Medi-Cal member who is enrolled in a county organized health system (COHS) plan is unhappy with their health plan, health network, or provider, the member can file a complaint or appeal with their health plan or the State Department of Social Services (DSS). The complaint or appeal must be submitted within 90 days of receiving a notice from the health plan or health network. This bill would allow members to file a complaint or appeal with DSS within 120 days of receiving the notice. This bill is related to the state's implementation of federal Medicaid managed care regulations.	**02/02/2017** Referred to Senate Committees on Health and Appropriations	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
SB 508 (Roth)	This bill would allow DHCS to create a dental health collaboration pilot program for Medi-Cal members in Riverside and San Bernardino counties. The program would coordinate efforts between health plans and DHCS to deliver more coordinated Denti-Cal services for Medi-Cal members and incentive based payment structures for Denti-Cal providers. According to the bill, this pilot program would be implemented for up to five years.	**03/20/2017** Referred to Senate Committee on Rules	Watch
State Budget Trailer Bill – Cal MediConnect	This trailer bill language (TBL) would establish statutory authority for the continuation of Cal MediConnect (CMC), which includes CalOptima's OneCare Connect. CMC is currently part of the Coordinated Care Initiative (CCI), which operates in seven counties and consists of both CMC, and the integration of Medi-Cal long-term services and supports, including In-Home Supportive Services (IHSS), into managed care. Gov. Brown's FY 2017–18 state budget proposed the continuation of CMC until December 31, 2019, even as the broader CCI is discontinued as of January 1, 2018. CCI's discontinuation means that IHSS administration will be transferred back to counties from managed care plans and that new state legislation will be required to authorize the CMC program past January 1, 2018.	**02/01/2017** Preliminary trailer bill language published by the Department of Finance	Watch

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
HR 1628 (Black)	The American Health Care Act (AHCA) would make sweeping changes to the national health care system. For CalOptima, the most significant changes would be 1) Changes to the Medicaid financing structure from the federal medical assistance percentage (FMAP) to a per capita cap system, 2) Decreased federal dollars for Medicaid expansion members who leave and return to the program, 3) Additional state authority to set "essential health benefit" requirements for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for state waiver programs.	**03/24/2017** Consideration of this bill has been postponed	Watch
S 191 (Cassidy)	The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, as well as the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination, pre-existing conditions exclusions, and annual/lifetime limits. Once the ACA provisions are repealed, the bill would provide greater state flexibility for their Medicaid and exchange programs. Specifically, states would be given three options after the ACA provisions are repealed: 1) A state-specific health system (excluding the repealed ACA provisions) with 95 percent of current federal funding available to states prior to implementation of this bill, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option 1 (state legislatures would be required to reinstate the ACA requirements and mandates repealed by S. 191).	**01/23/2017** Referred to Senate Committee on Finance	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

2017 State Legislative Deadlines

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2017 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

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

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

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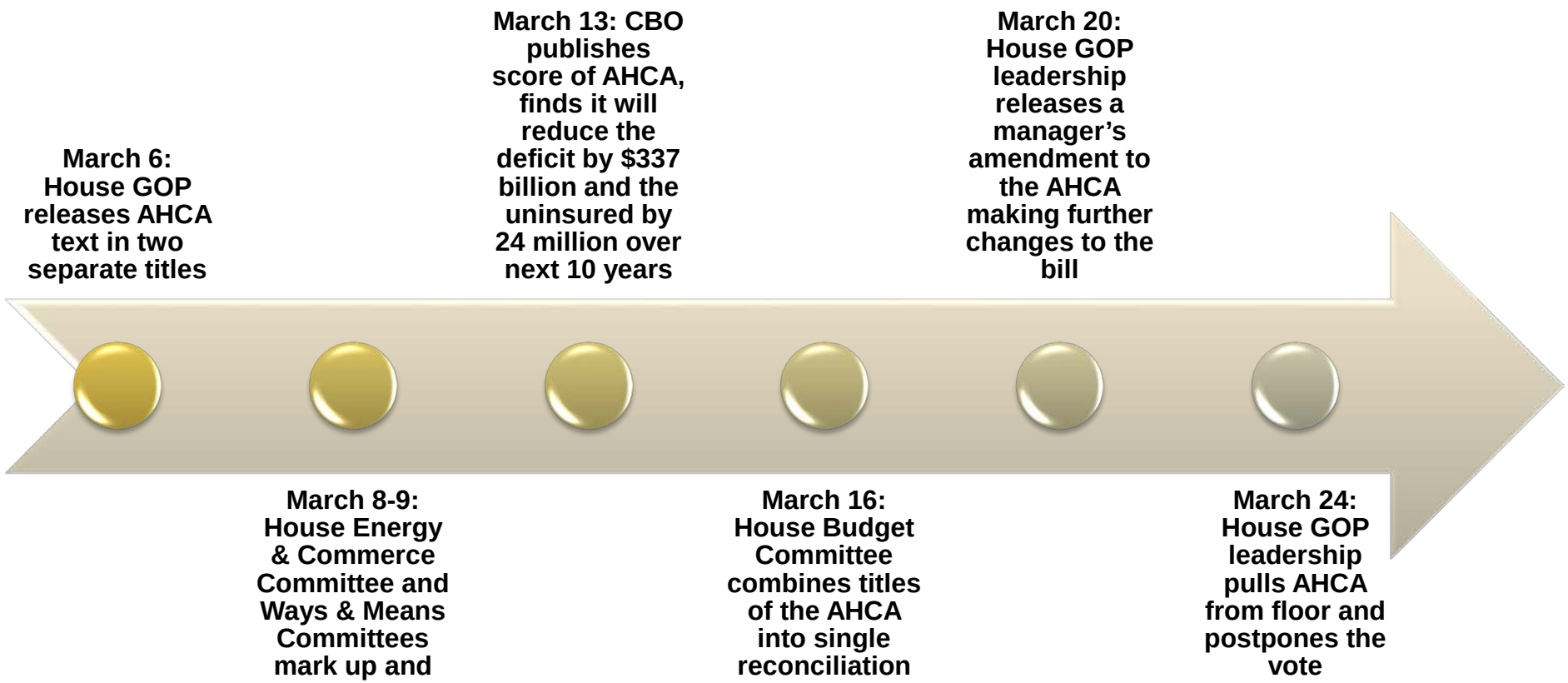
The American Health Care Act



CalOptima
A Public Agency
Better. Together.

March 24, 2017

Congressman Lou Correa
1039 Longworth House Office Building
U.S. House of Representatives

Congressman Ed Royce
2310 Rayburn House Office Building
U.S. House of Representatives

Congressman Darrell Issa
2269 Rayburn House Office Building
U.S. House of Representatives

Congressman Dana Rohrabacher
2300 Rayburn House Office Building
U.S. House of Representatives

Congressman Alan Lowenthal
125 Cannon House Office Building
U.S. House of Representatives

Congresswoman Linda Sanchez
2329 Rayburn House Office Building
U.S. House of Representatives

Congresswoman Mimi Walters
215 Cannon House Office Building
U.S. House of Representatives

Re: The American Health Care Act – Concerns and Proposals

Dear Representatives of Correa, Issa, Lowenthal, Rohrabacher, Royce, Sanchez, and Walters:

As you know, CalOptima is the not-for profit, community-based County Organized Health System (COHS) dedicated to ensuring the delivery of high quality and cost effective health care to Orange County's nearly 800,000 Medicaid beneficiaries, including over 230,000 individuals who gained coverage as a result of California's Medicaid expansion.

As Orange County's representatives in Congress, you can be proud of the care CalOptima provides to your constituents every day. In September 2016, the National Committee on Quality Assurance named CalOptima the top-rated Medi-Cal plan in California for the third year in a row and among the best in the nation.[1] CalOptima is also a trusted member of the Orange County community, promoting healthy behaviors through town halls, fairs, and workshops, and serves as an economic engine supporting health care jobs throughout its extensive provider network.

We write to you with strong concerns about the potential impact that the American Health Care Act (AHCA) may have on our ability to continue to provide high quality and cost effective health care to Orange County's Medicaid beneficiaries. Specifically, we are concerned that the reduced federal funding for Medicaid – accomplished primarily by freezing and phasing out the

[1] CalOptima press release, September 20, 2016: https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/NewsandPublications/2016/PR_2016-09-20_NCQARating_508.ashx

Medicaid expansion and converting the federal funding formula into a per capita cap system, among other provisions – will impose budgetary pressure on the State of California to make policy changes that lowers reimbursement rates for plans, restricts enrollee eligibility, or reduces existing services. The following concerns and proposals are intended as constructive ways to fulfill our shared goal of ensuring access to quality health care services delivered in a cost-effective manner for Orange County's low-income and disabled residents.

The Medicaid Continuous Coverage Requirement for Enhanced Federal Support

Section 112 of the AHCA would phase out the enhanced federal matching rate for new Medicaid expansion enrollees beginning after December 31, 2019. The state would continue to receive the enhanced federal matching rate only for those expansion enrollees that maintain continuous Medicaid coverage without any gap longer than one month. Approximately 30% of CalOptima's membership is covered by the Medicaid expansion, accounting for over $1 billion in CalOptima funding. As a result of this provision, the Congressional Budget Office estimated that "fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later" and "fewer than 5 percent of newly eligible enrollees by the end of 2024."[2]

The requirement that enrollees do not experience a break in coverage greater than one month in order to maintain the enhanced federal match will create a heavy regulatory burden on states to more frequently determine enrollee eligibility. The Medicaid eligibility re-determination process itself can often take longer than 30 days. Moreover, research demonstrates that Medicaid spending on adults decreases the longer they are continuously covered by the same plan rather than 'churning' through different types of coverage.

In order to ease the heavy regulatory burden and administrative costs on States that will be needed to comply with the 30-day requirement for maintaining the enhanced federal support, we ask that the AHCA include language allowing States to petition the Secretary of Health and Human Services for flexibility in administering this requirement. This flexibility could include an extension of the 30 day requirement with reasonable limits. Such flexibility would be at the option of the State in requesting it and at the discretion of the Secretary in granting it. We believe that such administrative flexibility is common in program implementation and would not undermine the intent of section 112.

Per Capita Caps Funding Level

Section 121 of the AHCA would convert the existing federal-State funding partnership for Medicaid into a capped payment from the federal government to the States based on historical per capita Medicaid spending by that State. The AHCA proposes to implement the new per capita cap funding formula in 2020 using as its base year the Medicaid enrollee spending from FY2016

[2] Congressional Budget Office cost estimate of the American Health Care Act, published March 13, 2017: https://www.cbo.gov/publication/52486

adjusted for medical inflation (CPI-M). As amended by the manager's amendment released on Monday March 20, 2017, the per capita cap would increase in subsequent years by CPI-M plus one percent for disabled and elderly enrollees and CPI-M for all other enrollees.

The base level funding and growth factors would lead to significantly lower than expected levels of federal funding for Medicaid. The CBO estimated on March 13 (prior to the manager's amendment released on March 20) that the AHCA would lead to "a reduction of $880 billion in federal outlays for Medicaid"[3] over the 2017-2026 period. CBO partially attributes this to the discrepancy in CPI-M, which is projected to grow at an average annual rate of 3.7 percent over the next ten years, and Medicaid spending, which is projected to grow at an average annual rate of 4.4 percent over the same period. As a result, the California Department of Health Care Services (DHCS) which are responsible for administering Medi-Cal in California, in collaboration with the California Department of Finance, estimate that switching to a per capita funding based model as proposed by the AHCA would lead the state to be responsible for $680 million in 2020 growing to $5.3 billion by 2027.[4]

Our strong concern, reinforced by the CBO and California DHCS estimates, is that the increasing disparity over time between the federal per capita cap and actual Medicaid spending will impose budgetary pressure on expansion states like California to choose to reduce Medicaid spending through lowering rates to plans, ending certain optional services, or restricting enrollment eligibility. We strongly urge that the AHCA or any subsequent legislation to establish per capita caps include federal funding levels and growth rates commensurate with the expected increase in Medicaid spending and sufficient to fulfill the mission of delivering quality, cost-effective care.

Conclusion

CalOptima stands ready to provide additional expertise in the further development of these and other legislative proposals. We look forward to working with you and serving as a trusted resource as Congress continues to amend the American Health Care Act with the shared goal of improving access, quality, and value in the health care system.

Sincerely,

Michael Schrader
Chief Executive Officer

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[3] Congressional Budget Office cost estimate of the American Health Care Act, published March 13, 2017: https://www.cbo.gov/publication/52486

[4] State of California, Health and Human Services Agency, Department of Health Care Services, March 21, 2017: http://www.dhcs.ca.gov/Documents/3.21.17_AHCA_Fiscal_Analysis.pd.pdf