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

THURSDAY, NOVEMBER 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 October 12, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

V. REPORTS

A. Consider Recommendation of Agency-Appointed Representative from Orange County Health Care Agency (OCHCA)

VI. CEO AND MANAGEMENT REPORTS

A. Chief Executive Officer (CEO) Update
B. Chief Operating Officer (COO) Update
C. Chief Medical Officer (CMO) Update
D. Chief Financial Officer (CFO) Update
E. Network Operations Update
F. Federal and State Legislative Update

VII. INFORMATION ITEMS

A. Community Referral Network
B. Palliative Care Update
C. Women's Mental Health Issues
D. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

Back to Agenda

MINUTES

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

October 12, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, October 12, 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 8:07 a.m., and Member Pham led the Pledge of Allegiance.

ESTABLISH QUORUM

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

Members Absent: John Nishimoto, O.D.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Edwin Poon, PhD, Director, Behavioral Health Services; Sandeep Mital, Manager, Quality Initiatives; Cheryl Simmons, Staff to the Provider Advisory Committee

MINUTES

Approve the Minutes of the August 10, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Vice Chair Richards, seconded and carried, the Committee approved the minutes of the August 10, 2017 meeting. (Motion carried 14-0-0; Member Nishimoto absent)***

Back to Agenda

Approve the Minutes of the September 14, 2017 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee and the Provider Advisory Committee

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the minutes of the September 14, 2017 meeting. (Motion carried 14-0-0; Member Nishimoto absent.)***

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, gave a brief update on the behavioral health Medi-Cal transition from Magellan Healthcare and noted that CalOptima is holding daily meetings and moving forward with hiring staff necessary for this transition. Ms. Khamseh also briefly discussed the continuing interest in some quarters in considering the possibility of CalOptima in obtaining a Knox-Keene License for medical even though this license is not a requirement for County Organization Health System (COHS) plans. She also noted that CalOptima is considering establishing an Independent Medical Reviews (IMR) process.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer, announced that for the fourth year in a row, CalOptima was again rated California's top Medi-Cal plan, according to the National Committee for Quality Assurance (NCQA) Plan Ratings 2017-2018.

Dr. Bock introduced Sandeep Mital, Manager of Quality Analytics, who gave a verbal report on the Data Collection workgroup that was created to help solve data issues related to the Pay for Value (P4V) and Healthcare Effectiveness Data and Information Set (HEDIS) programs. The health networks and CalOptima are collaborating to ensure all data is captured including the State's California Immunization Registry (CAIR).

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's draft Financial Summary as of August 2017, including a report of the Health Network Enrollment for the month. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Network Operation Update

Michelle Laughlin, Executive Director Network Operations, provided an update on the Magellan transition, with the goal to retain the majority of providers for Applied Behavior Analysis (ABA) and Behavioral Health services. Ms. Laughlin also noted that Magellan will be returning the behavioral health member telephone number to CalOptima. This telephone number is noted on CalOptima member Medi-Cal cards, so continuing to use this number will help to make the upcoming transition seamless.

Back to Agenda

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided an update on the Children's Health Insurance Program (CHIP), and noted that a reauthorization was signed in to law in 2015, which funded CHIP through September 30, 2017. The current funding is split between Federal and State at 88% and 12%, respectively. Mr. Tsunoda discussed the various scenarios under consideration to fund the CHIP program

INFORMATION ITEMS

Behavioral Health Update

Edwin Poon, PhD, Director, Behavioral Health Services, presented a follow up to Sandra Fair's Drug Medi-Cal presentation at the September Joint MAC/PAC meeting, noting that 37% of the total referrals are for Alcohol and Drug Residential services, 17% for outpatient behavioral health therapy, and 50% for Magellan (mild to moderate) therapy services.

Whole Child Care Model

Candice Gomez, Executive Director, Program Implementation, provided a status on the transition plan for the Whole Child Care Model effective January 1, 2019. PAC members had questions regarding the provider network and the reimbursement after the program transitions to CalOptima. PAC members also questioned what the definition of Community Based Organization (CBO) was for the two seats that will serve on the new advisory committee that will be formed for the California Children's Services (CCS) program.

Palliative Care Update

This presentation was continued to the November 2017 meeting.

PAC Member Information

Chair Miranti reminded the PAC members that the next meeting is scheduled for November 9, 2017 and that the first quarter goals and objectives will be reviewed at that meeting. She also reminded the PAC members that mandatory compliance training must be completed by November 3, 2017.

ADJOURNMENT

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

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: November 9, 2017

Back to Agenda

MEMORANDUM

DATE:	November 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

Executive Team
CalOptima recently welcomed Greg Hamblin and Lori Shaw as Chief Financial Officer and Executive Director, Human Resources, respectively. Both were hired after national recruitments conducted over several months. Most recently, Mr. Hamblin was vice president of finance for Molina Healthcare Inc. Prior to that, he was CFO for Molina Healthcare of California, where he gained experience in lines of business like CalOptima's, including Medi-Cal plans, Dual Eligible Special Needs Plans (OneCare) and Medicare-Medicaid Plans (OneCare Connect). Ms. Shaw comes to us with nearly 20 years of HR leadership in a variety of health care organizations, including hospitals, clinics and health plans. Most recently, she was HR director for Alliance Healthcare Services in Irvine, and she also worked for Optum, the parent company for Monarch HealthCare. She has experience with training, coaching, employee engagement and organization culture. I look forward to their significant contributions to CalOptima and our mission.

Quality Recognition
CalOptima and our provider partners have much to celebrate! Our Better. Together. effort to deliver quality care for members was recognized twice in the past two months. First, in September, CalOptima was again rated California's top Medi-Cal plan, according to the NCQA's Medicaid Health Insurance Plan Ratings 2017–2018. It is the fourth year in a row that NCQA has named CalOptima best overall in the state. Second, at the Department of Health Care Services (DHCS) Quality Conference in October, CalOptima was honored with the Outstanding Performance Award for a Large Scale Medi-Cal Plan. The DHCS award is based on 2016 HEDIS results. These latest awards are objective measures that CalOptima is fulfilling our mission. Thanks to your Board for your ongoing support and guidance!

Program of All-Inclusive Care for the Elderly (PACE)
Progress continues in our effort to expand PACE into South Orange County, and staff is working on three initiatives in parallel. First, on October 16, CalOptima submitted a Notice of Intent to Apply for Service Area Expansion (SAE) to DHCS. This is the initial step for an SAE filing in fourth quarter of 2017. Once we submit the application, it can take six to nine months for review and approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS). Approval of an expanded service area is contingent upon strategies being in place to provide the PACE model of care countywide. The Board-approved strategies that will make expansion possible are the use of Alternative Care Setting (ACS) sites and community-based physicians,

Back to Agenda

which represent our second and third ongoing initiatives. Regarding ACS, CalOptima released a Request for Proposal (RFP) for ACS sites, and we anticipate that several Community-Based Adult Services centers will respond. Finally, regarding community-based physicians, CalOptima submitted a waiver in September to DHCS and CMS. Staff anticipate implementing the community-based physician strategy no sooner than the second quarter of 2018. Separately, in August, the state released a PACE draft policy letter and solicited comments. The draft letter: 1) Prohibits a PACE organization from delegating PACE operations to a separate entity, 2) Allows the use of ACS sites, and 3) Creates a process with multiple approvals for outside PACE operators to open in county organized health system (COHS) counties without oversight by the COHS plan. CalOptima submitted comments consistent with protecting the COHS model while allowing appropriate delegation of selected PACE services, but it is our understanding that the three principles in the draft are likely to remain when the final policy letter is released. In the meantime, I will continue updating your Board on PACE expansion activities, and staff will return to a future Board meeting to request authorization to contract with ACS sites and community-based physicians.

Behavioral Health (BH) Transition
Staff are making significant progress in preparation for the January 1, 2018, transition of the BH benefit from Magellan Healthcare to CalOptima. The development of the provider network is well underway. In September, we mailed contracts to 550 mental health services providers, conducting outreach to the 140 providers who collectively deliver 90 percent of the services. In October, CalOptima mailed contracts to 70 Applied Behavior Analysis (ABA) vendors. To remain transparent and collaborative, CalOptima held a meeting with ABA vendors on October 10, 2017, in part to discuss the rates, which are set for 2018 based on a fixed and limited ABA budget from the state. The next meeting with ABA vendors is scheduled for October 25, 2017.

California Children's Services (CCS)
One of DHCS's highest priorities for 2018 is the transition of critical components of the CCS program from counties to COHS plans, including CalOptima. This will be a major initiative for CalOptima in 2018, as we have the largest CCS population among the COHS plans included in the transition. The transition from the Orange County Health Care Agency to CalOptima becomes effective January 1, 2019. In the coming months, I will share information with your Board regarding our transition plan with the County and our engagement with CCS families and providers. Our goal across the transition is for these children to have continued access to the same PCPs, specialists, hospitals, durable medical equipment suppliers, and other providers essential to their care.

Funding Distributions
CalOptima made two significant funding distributions to health networks and hospitals in recent weeks. In September, health networks with shared risk group contracts received shared risk pool distributions totaling approximately $160 million for FY 2015. On behalf of hospitals, CalOptima received from the state a $271 million Quality Assurance Fee (QAF) payment covering FY 2015–16. As you know, the DHCS QAF program provides supplemental payments to hospitals through managed care plans. Following the Hospital Association of Southern

Back to Agenda

California distribution schedule, CalOptima released these funds to Orange County hospitals in late October.

Intergovernmental Transfers

Using funds from IGT 4, CalOptima's first comprehensive Member Health Needs Assessment is well underway. To date, staff has coordinated 28 member focus groups throughout Orange County. The focus groups have been conducted in all seven threshold languages (plus two additional languages), targeting a broad spectrum of member populations, including parents of children with autism, homeless members, older adults, teens, working adults, members with disabilities and other. In addition, CalOptima consultants have conducted 24 key stakeholder interviews with community leaders, service providers and members of your Board. The final assessment will also include data gathered from 5,542 completed member surveys, collected either by mail, online or telephone. Staff plans to share an executive summary with your Board next month. Separately, CalOptima received payment from DHCS for IGT 6, and CalOptima's share of these funds totals $15.2 million. We expect to receive $12.1 million from IGT 7 in early spring, bringing the anticipated cumulative IGT 6 and 7 funding total to $27.3 million. Staff has developed an IGT 6 and 7 Expenditure Plan process, and the first step was executed on October 19, with the release of a solicitation for Letters of Interest from organizations interested in working on projects in three Board-approved areas: Opioid and Other Substance Overuse, Homeless Health, and Children's Mental Health. Due by November 13, the letters will be used to guide grant funding allocation amounts. Grant funding applications will be released in early 2018.

Key Meetings

- *Health Network CEO Meeting*: On September 13, CalOptima held our quarterly meeting with leadership of the health networks. The meeting covered various topics, including CalOptima administration of the Medi-Cal BH benefit starting on January 1, 2018; the Whole Person Care program's use of recuperative care; the state medical loss ratio (MLR) audit of CalOptima sometime in the future; CalOptima's MLR audits of health networks; CalOptima's risk-pool distributions to health networks with shared risk group agreements; and possible reductions to rates for Medi-Cal Expansion members starting July 1, 2018.
- *Joint Advisory Committee Meeting*: On September 14, CalOptima's Member and Provider Advisory Committees came together for a joint meeting. The agenda featured presentations that highlighted Orange County's impressive work in serving people who are homeless or who have substance use disorders. Orange County Director of Care Coordination Susan Price spoke about the growth in the homeless population and current interventions, while Sandra Fair, administrative manager of Behavioral Health Services at the Orange County Health Care Agency, covered the County's five-year pilot project to strengthen Drug Medi-Cal.
- *Local Health Plans of California (LHPC)*: On October 9, I attended the LHPC Board meeting in Huntington Beach. Department of Managed Health Care Director Shelley Rouillard provided an update about the regulator's activities, including in the priority areas of provider directories, timely access to care and clinical quality improvement. Another key element of the meeting was the development of a document outlining the association's principles regarding universal coverage. Considering the passage of a single-payer bill in the California State Senate (before it was held in the Assembly) and the attention on Sen. Bernie

Back to Agenda

Sanders' bill in Washington, D.C., my fellow LHPC Board members and I think the best course of action is to set forth key principles that will be used to evaluate proposals in future state or federal legislative efforts. As a COHS, CalOptima has an interest in ensuring access to care. However, we believe that any reform efforts should build upon the success of Medi-Cal managed care plans in expanding coverage thus far. The current versions of the single-payer bills are based upon the fee-for-service delivery model.

- *California Association of Health Plans (CAHP)*: On October 10, as part of the CAHP Board meeting and separate dinner in the evening, I attended the CAHP Annual Conference in Huntington Beach. Among other topics, CAHP leaders highlighted the association's aggressive advocacy effort on prescription drug price transparency, which resulted in the passage of SB 17. The governor signed the bill, now requiring drug companies to give payers notice of major price increases and time to plan for the increases. SB 17 was sponsored by Sen. Ed Hernandez, who also spoke at the conference.
- *Annual Healthy Smiles Gala***:** On October 21, a few CalOptima staff including myself attended the Annual Healthy Smiles Gala at the Bowers museum to receive the Community Partner of the Year award, on behalf of CalOptima. I spoke at the event and described how "Better. Together." CalOptima and Healthy Smiles serve many of the same children from low-income families in Orange County.

Back to Agenda

Financial Summary

September 2017

Board of Directors Meeting

November 2, 2017

Greg Hamblin

Chief Financial Officer

Back to Agenda

FY 2017-18: Consolidated Enrollment

- September 2017 MTD:
  - Overall enrollment was 796,181 member months
    - Actual lower than budget by 6,192 or 0.8%
      - Medi-Cal: unfavorable variance of 6,013 members
        - TANF unfavorable variance of 9,620 members
        - SPD unfavorable variance of 1,982 members
        - Medi-Cal Expansion (MCE) favorable variance of 5,343 members
        - LTC favorable variance of 246 members
      - OneCare Connect: unfavorable variance of 251 members
    - 1,810 or 0.2% decrease from prior month
      - Medi-Cal: decrease of 1,871 from August
      - OneCare Connect: increase of 36 from August
      - OneCare: increase of 18 from August
      - PACE: increase of 7 from August

FY 2017-18: Consolidated Enrollment

- September 2017 YTD:
  - Overall enrollment was 2,381,858 member months
    - Actual lower than budget by 24,277 or 1.0%
      - Medi-Cal: unfavorable variance of 23,813 members or 1.0%
        - TANF unfavorable variance of 30,767 members
        - SPD unfavorable variance of 6,716 members
        - MCE favorable variance of 13,090 members
        - LTC favorable variance of 580 members
      - OneCare Connect: unfavorable variance of 648 members or 1.4%
      - OneCare: favorable variance of 183 members or 4.6%
      - PACE: favorable variance of 1 member or 0.2%

FY 2017-18: Consolidated Revenues

- September 2017 MTD:
  - ➢ Actual higher than budget by $22.1 million or 8.0%
    - Medi-Cal: favorable to budget by $17.5 million or 7.2%
      - Unfavorable volume variance of $1.9 million
      - Favorable price variance of $19.4 million due to:
        - ➢ $9.5 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services (IHSS) revenue
        - ➢ $2.0 million of fiscal year 2018 Behavior Health Treatment (BHT) revenue
        - ➢ $2.1 million of fiscal year 2018 LTC related revenue from non-LTC aid code
        - ➢ $1.2 million of fiscal year 2018 Non-Medical Transportation revenue
        - ➢ $3.7 million of fiscal year 2016 revenue true up to final DHCS rates

FY 2017-18: Consolidated Revenues (cont.)

- September 2017 MTD:
  - OneCare Connect: favorable to budget by $6.9 million or 25.0%
    - Unfavorable volume variance of $0.4 million due to lower enrollment
    - Favorable price related variance of $7.4 million due to CMS' annual adjustments
  - OneCare: unfavorable to budget by $2.5 million or 178.6%
    - $2.8 million due to prior year Health Network recoupment due to encounter data correction
  - PACE: favorable to budget by $0.1 million or 8.7%

FY 2017-18: Consolidated Revenues (cont.)

- September 2017 YTD:
  - Actual higher than budget by $33.8 million or 4.1%
    - Medi-Cal: favorable to budget by $29.9 million or 4.1%
      - Unfavorable volume variance of $7.4 million
      - Favorable price variance of $37.4 million due to:
        - $19.0 million for CCI and IHSS revenue
        - $14.5 million for prior year revenue
        - $4.5 million for Autism revenue
    - OneCare Connect: favorable to budget by $5.7 million or 6.9%
      - Unfavorable volume variance of $1.1 million
      - Favorable price variance of $6.8 million
    - OneCare: Unfavorable to budget by $2.3 million or 55.9%
      - Favorable volume variance of $0.2 million
      - Unfavorable price variance of $2.5 million
        - $2.8 million due to Health Network recoupment
    - PACE: favorable to budget by $0.5 million or 11.5%

FY 2017-18: Consolidated Medical Expenses

- September 2017 MTD:
  - ➢ Actual higher than budget by $18.9 million or 7.3%
    - ▪ Medi-Cal: unfavorable variance of $19.4 million
      - MLTSS unfavorable variance of $8.5 million
        - ➢ IHSS unfavorable variance of $4.9 million
        - ➢ Nursing facilities expenses unfavorable variance of $2.8 million
      - Professional Claims unfavorable variance of $5.7 million
      - Provider Capitation unfavorable variance of $3.0 million
      - Facilities expenses unfavorable variance of $1.6 million

    - OneCare Connect: unfavorable variance of $2.7 million
      - Favorable volume variance of $0.4 million
      - Unfavorable price variance of $3.1 million

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

- September 2017 YTD:
  - Actual higher than budget by $43.4 million or 5.5%
    - Medi-Cal: unfavorable variance of $44.0 million
      - Favorable volume variance of $7.1 million
      - Unfavorable price variance of $51.0 million
        - MLTSS expense $23.1 million higher than budget
        - Professional Claims $6.6 million higher than budget
        - Facilities $6.2 million higher than budget
        - Provider Capitation $5.9 million higher than budget
    - OneCare Connect: unfavorable variance of $2.8 million
      - Favorable volume variance of $1.1 million
      - Unfavorable price variance of $3.9 million
- Medical Loss Ratio (MLR):
  - September 2017 MTD: Actual: 93.3% Budget: 93.9%
  - September 2017 YTD: Actual: 96.2% Budget: 94.8%

Back to Agenda

FY 2017-18: Consolidated Administrative Expenses

- September 2017 MTD:
  - ➢ Actual lower than budget by $2.1 million or 18.0%
    - Salaries and Benefits: favorable variance of $0.8 million
    - Other categories: favorable variance of $1.4 million

- September 2017 YTD:
  - ➢ Actual lower than budget by $8.0 million or 22.0%
    - Salaries and Benefits: favorable variance of $2.7 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $5.2 million

- Administrative Loss Ratio (ALR):
  - ➢ September 2017 MTD: Actual: 3.3% Budget: 4.3%
  - ➢ September 2017 YTD: Actual: 3.3% Budget: 4.4%

FY 2017-18: Change in Net Assets

- September 2017 MTD:
  - $11.3 million surplus
  - $6.2 million favorable to budget
    - Higher than budgeted revenue of $22.1 million
    - Higher than budgeted medical expenses of $18.9 million
    - Lower than budgeted administrative expenses of $2.1 million
    - Higher than budgeted investment and other income of $0.9 million

- September 2017 YTD:
  - $11.3 million surplus
  - $4.1 million favorable to budget
    - Higher than budgeted revenue of $33.8 million
    - Higher than budgeted medical expenses of $43.4 million
    - Lower than budgeted administrative expenses of $8.0 million
    - Higher than budgeted investment and other income of $5.7 million

Enrollment Summary: September 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
62,289	62,630	(341)	(0.5%)	Aged	185,000	186,724	(1,724)	(0.9%)
625	618	7	1.1%	BCCTP	1,877	1,854	23	1.2%
47,116	48,764	(1,648)	(3.4%)	Disabled	141,249	146,264	(5,015)	(3.4%)
327,786	329,785	(1,999)	(0.6%)	TANF Child	982,305	989,784	(7,479)	(0.8%)
96,310	103,931	(7,621)	(7.3%)	TANF Adult	288,774	312,062	(23,288)	(7.5%)
3,514	3,268	246	7.5%	LTC	10,384	9,804	580	5.9%
241,644	236,301	5,343	2.3%	MCE	721,589	708,499	13,090	1.8%
779,284	**785,297**	**(6,013)**	**(0.8%)**	**Medi-Cal**	**2,331,178**	**2,354,991**	**(23,813)**	**(1.0%)**
15,265	**15,516**	**(251)**	**(1.6%)**	**OneCare Connect**	**45,859**	**46,507**	**(648)**	**(1.4%)**
228	**226**	**2**	**0.9%**	**PACE**	**664**	**663**	**1**	**0.2%**
1,404	**1,334**	**70**	**5.2%**	**OneCare**	**4,157**	**3,974**	**183**	**4.6%**
796,181	**802,373**	**(6,192)**	**(0.8%)**	**CalOptima Total**	**2,381,858**	**2,406,135**	**(24,277)**	**(1.0%)**

Back to Agenda

Financial Highlights: September 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
796,181	802,373	(6,192)	(0.8%)	Member Months	2,381,858	2,406,135	(24,277)	(1.0%)
297,732,356	275,642,096	22,090,259	8.0%	Revenues	859,083,252	825,259,966	33,823,286	4.1%
277,812,491	258,936,834	(18,875,657)	(7.3%)	Medical Expenses	826,083,672	782,662,834	(43,420,838)	(5.5%)
9,744,789	11,884,562	2,139,773	18.0%	Administrative Expenses	28,137,763	36,094,325	7,956,562	22.0%
10,175,076	**4,820,699**	**5,354,376**	**111.1%**	**Operating Margin**	**4,861,818**	**6,502,807**	**(1,640,989)**	**(25.2%)**
1,103,744	231,157	872,586	377.5%	Non Operating Income (Loss)	6,446,929	736,245	5,710,684	775.6%
11,278,819	**5,051,857**	**6,226,963**	**123.3%**	**Change in Net Assets**	**11,308,747**	**7,239,053**	**4,069,695**	**56.2%**
93.3%	93.9%	0.6%		Medical Loss Ratio	96.2%	94.8%	(1.3%)	
3.3%	4.3%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
3.4%	1.7%	1.7%		Operating Margin Ratio	0.6%	0.8%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima A Public Agency Better. Together.

Back to Agenda

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	4.4	0.1	Medi-Cal	(0.2)	7.0	(7.3)
4.8	0.5	4.3	OCC	3.9	0.1	3.8
0.6	(0.1)	0.7	OneCare	0.6	(0.5)	1.1
0.2	0.0	0.2	PACE	0.6	(0.2)	0.8
10.2	**4.8**	**5.3**	**Operating**	**4.8**	**6.5**	**(1.7)**
1.1	0.2	0.9	Inv./Rental Inc, MCO tax	6.5	0.7	5.6
1.1	**0.2**	**0.9**	**Non-Operating**	**6.5**	**0.7**	**5.6**
11.3	**5.1**	**6.2**	**TOTAL**	**11.3**	**7.2**	**4.1**

Back to Agenda

Consolidated Revenue & Expense: September 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	537,640	241,644	779,284	15,265	1,404	228	796,181
REVENUES							
Capitation Revenue	$ 150,153,121	$ 112,403,119	$ 262,556,241	$ 34,652,381	$ (1,094,261)	$ 1,617,995	$ 297,732,356
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	150,153,121	112,403,119	262,556,241	34,652,381	(1,094,261)	1,617,995	297,732,356
MEDICAL EXPENSES							
Provider Capitation	39,521,013	50,516,924	90,037,937	12,661,156	(2,247,990)	-	100,451,103
Facilities	21,198,993	23,496,321	44,695,314	3,586,012	62,118	184,354	48,527,798
Ancillary	-	-	-	568,797	3,266	-	572,063
Skilled Nursing	-	-	-	-	4,755	-	4,755
Professional Claims	13,845,447	5,597,700	19,443,147	-	-	346,516	19,789,663
Prescription Drugs	17,144,885	17,703,599	34,848,484	4,855,851	433,808	106,728	40,244,871
MLTSS Facility Payments	54,232,017	2,632,094	56,864,111	5,271,733	-	(368)	62,135,476
Medical Management	1,724,254	840,902	2,565,156	939,878	11,324	365,196	3,881,553
Reinsurance & Other	1,076,858	693,939	1,770,797	141,469	7,278	285,664	2,205,208
Total Medical Expenses	148,743,468	101,481,478	250,224,946	28,024,897	(1,725,441)	1,288,089	277,812,491
Medical Loss Ratio	**99.1%**	**90.3%**	**95.3%**	**80.9%**	**157.7%**	**79.6%**	**93.3%**
GROSS MARGIN	**1,409,654**	**10,921,641**	**12,331,295**	**6,627,484**	**631,180**	**329,906**	**19,919,864**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,107,223	746,311	21,015	60,691	5,935,240
Professional fees			172,881	17,875	0	2,935	193,691
Purchased services			903,190	85,998	12,483	6,246	1,007,918
Printing and Postage			406,533	83,461	(1,478)	68	488,584
Depreciation and Amortization			617,605	-	-	2,168	619,773
Other expenses			1,104,253	37,915	(0)	22,718	1,164,886
Indirect cost allocation, Occupancy expense			(493,564)	825,539	(23,161)	25,882	334,696
Total Administrative Expenses			7,818,122	1,797,098	8,859	120,709	9,744,789
Admin Loss Ratio			**3.0%**	**5.2%**	**-0.8%**	**7.5%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			4,513,173	4,830,386	622,321	209,196	10,175,076
INVESTMENT INCOME			-	-	-	-	1,105,625
NET RENTAL INCOME			-	-	-	-	8,604
NET GRANT INCOME			(10,546)	-	-	-	(10,546)
OTHER INCOME			60	-	-	-	60
CHANGE IN NET ASSETS			**$ 4,502,687**	**$ 4,830,386**	**$ 622,321**	**$ 209,196**	**$ 11,278,819**
BUDGETED CHANGE IN ASSETS			4,418,128	539,315	(108,323)	(28,421)	5,051,857
VARIANCE TO BUDGET - FAV (UNFAV)			84,559	4,291,071	730,643	237,617	6,226,963

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Back to Agenda

Consolidated Revenue & Expense: September 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,609,589	721,589	2,331,178	45,859	4,157	664	2,381,858
REVENUES							
Capitation Revenue	$ 447,628,650	$ 317,030,364	$ 764,659,014	$ 87,771,776	1,789,381	$ 4,863,081	$ 859,083,252
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	447,628,650	317,030,364	764,659,014	87,771,776	1,789,381	4,863,081	859,083,252
MEDICAL EXPENSES							
Provider Capitation	116,660,817	150,511,678	267,172,495	33,890,040	(1,456,604)	-	299,605,931
Facilities	65,186,053	72,037,091	137,223,144	9,113,530	836,510	818,515	147,991,699
Ancillary	-	-	-	1,891,519	85,461	-	1,976,980
Skilled Nursing	-	-	-	-	52,555	-	52,555
Professional Claims	34,331,176	13,827,753	48,158,929	-	-	974,238	49,133,167
Prescription Drugs	53,038,033	55,184,173	108,222,206	15,102,448	1,420,929	328,933	125,074,516
MLTSS Facility Payments	162,706,147	7,489,698	170,195,846	15,375,481	-	16,390	185,587,717
Medical Management	6,422,964	1,933,895	8,356,860	3,139,968	51,302	1,091,944	12,640,073
Reinsurance & Other	1,726,651	971,988	2,698,639	570,027	21,350	731,018	4,021,034
Total Medical Expenses	440,071,842	301,956,277	742,028,118	79,083,014	1,011,502	3,961,037	826,083,672
Medical Loss Ratio	**98.3%**	**95.2%**	**97.0%**	**90.1%**	**56.5%**	**81.5%**	**96.2%**
GROSS MARGIN	**7,556,809**	**15,074,087**	**22,630,896**	**8,688,762**	**777,879**	**902,044**	**32,999,581**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			15,468,566	2,236,999	75,591	207,960	17,989,116
Professional fees			561,068	18,376	0	9,040	588,484
Purchased services			2,376,469	259,764	38,574	12,424	2,687,231
Printing and Postage			822,006	148,718	8,572	4,995	984,291
Depreciation and Amortization			1,372,600	-	-	6,432	1,379,032
Other expenses			3,268,243	147,882	(0)	53,886	3,470,010
Indirect cost allocation, Occupancy expense			(1,026,800)	1,994,395	40,659	31,344	1,039,598
Total Administrative Expenses			22,842,152	4,806,133	163,396	326,081	28,137,763
Admin Loss Ratio			**3.0%**	**5.5%**	**9.1%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(211,256)	3,882,629	614,483	575,962	4,861,818
INVESTMENT INCOME			-	-	-	-	6,460,129
NET RENTAL INCOME			-	-	-	-	15,244
NET GRANT INCOME			(28,863)	-	-	-	(28,863)
OTHER INCOME			419	-	-	-	419
CHANGE IN NET ASSETS			**$ (239,700)**	**$ 3,882,629**	**$ 614,483**	**$ 575,962**	**$ 11,308,747**
BUDGETED CHANGE IN ASSETS			7,033,341	102,010	(452,152)	(180,391)	7,239,053
VARIANCE TO BUDGET - FAV (UNFAV)			(7,273,041)	3,780,619	1,066,634	756,354	4,069,695

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Back to Agenda

Balance Sheet:
As of September 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$761,478,642	Accounts payable	$19,618,674
	Investments	1,041,355,043	Medical claims liability	1,422,870,300
	Capitation receivable	385,861,846	Accrued payroll liabilities	11,089,422
	Receivables - Other	24,750,232	Deferred revenue	156,973,782
	Prepaid Expenses	4,978,217	Deferred lease obligations	178,046
			Capitation and withholds	437,934,816
	Total Current Assets	**2,218,423,981**	**Total Current Liabilities**	**2,048,665,040**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,105,495
	Building/Leasehold improvements	5,527,436		
	505 City Parkway West	49,433,337	Net Pension Liabilities	15,959,420
		88,999,822	Long Term Liabilities	100,000
	Less: accumulated depreciation	(36,454,633)		
	Capital assets, net	**52,545,189**	**TOTAL LIABILITIES**	**2,093,829,955**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings	-
			Deferred inflows of Resources - Changes in Assumptions	1,340,010
	Board-designated assets			
	Cash and cash equivalents	23,363,148	Tangible net equity (TNE)	92,041,987
	Long term investments	513,727,647	Funds in excess of TNE	632,725,153
	Total Board-designated Assets	537,090,795		
	Total Other Assets	**537,390,795**	**Net Assets**	**724,767,140**
	Deferred outflows of Resources - Pension Contributions	5,234,198		
	Deferred outflows of Resources - Difference in Experience	1,072,771		
	Deferred outflows of Resources - Excess Earnings	5,270,171		
TOTAL ASSETS & OUTFLOWS		**2,819,937,104**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,819,937,104**

Back to Agenda

Board Designated Reserve and TNE Analysis
As of September 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,756,598				
	Tier 1 - Logan Circle	146,506,854				
	Tier 1 - Wells Capital	146,471,481				
Board-designated Reserve		439,734,933	304,283,513	474,137,298	135,451,420	(34,402,366)
TNE Requirement	Tier 2 - Logan Circle	97,355,862	92,041,987	92,041,987	5,313,875	5,313,875
	Consolidated:	537,090,795	396,325,500	566,179,285	140,765,295	(29,088,491)
	Current reserve level	*1.90*	*1.40*	*2.00*		

Back to Agenda

HN Enrollment Summary - Medi-Cal

Health Network Name	OCTOBER 2017	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	150,480	19.4%	22.4%
Monarch Family HealthCare (HMO16)	85,336	11.0%	12.7%
CalOptima Community Network (CN)	74,546	9.6%	11.1%
Arta Western Health Network (SRG66)	68,676	8.9%	10.2%
Family Choice Health Network (PHC21)	47,372	6.1%	7.1%
Kaiser Permanente (HMO04)	45,956	5.9%	6.9%
Alta Med Health Services (SRG69)	45,479	5.9%	6.8%
Prospect Medical Group (HMO17)	35,102	4.5%	5.2%
United Care Medical Network (SRG67)	34,452	4.5%	5.1%
Noble Mid-Orange County (SRG64)	29,534	3.8%	4.4%
Talbert Medical Group (SRG65)	23,517	3.0%	3.5%
AMVI Care Health Network (PHC58)	23,415	3.0%	3.5%
Heritage - Regal Medical Group (HMO15)	5,033	0.7%	0.8%
OC Advantage (PHC35)	1,655	0.2%	0.2%
Total Health Network Capitated Enrollment	**670,552**	**86.6%**	**100.0%**
CalOptima Direct (all others)	103,453	13.4%	
Total Medi-Cal Enrollment	**774,005**	**100.0%**	

HN Enrollment Summary – OneCare Connect

Health Network Name	OCTOBER 2017	Percentage
Monarch HealthCare (HMO16DB)	4,887	32.0%
Propect Medical Group (HMO17DB)	2,846	18.6%
Family Choice Medical Group (SRG81DB)	1,864	12.2%
CalOptima Community Network (CN)	1,724	11.3%
Talbert Medical Group (SRG52DB)	1,130	7.4%
Arta Western Health Network(SRG66DB)	525	3.4%
United Care Medical Group (SRG67DB)	520	3.4%
Alta-Med (SRG69DB)	518	3.4%
AMVI Care Health Network (PHC58DB)	468	3.1%
Noble Mid Orange County (SRG64DB)	448	2.9%
Heritage - Regal Medical Group (HMO15)	224	1.5%
OC Advantage (PHC35DB)	111	0.7%
Total OneCare Connect Enrollment	**15,265**	**100.0%**

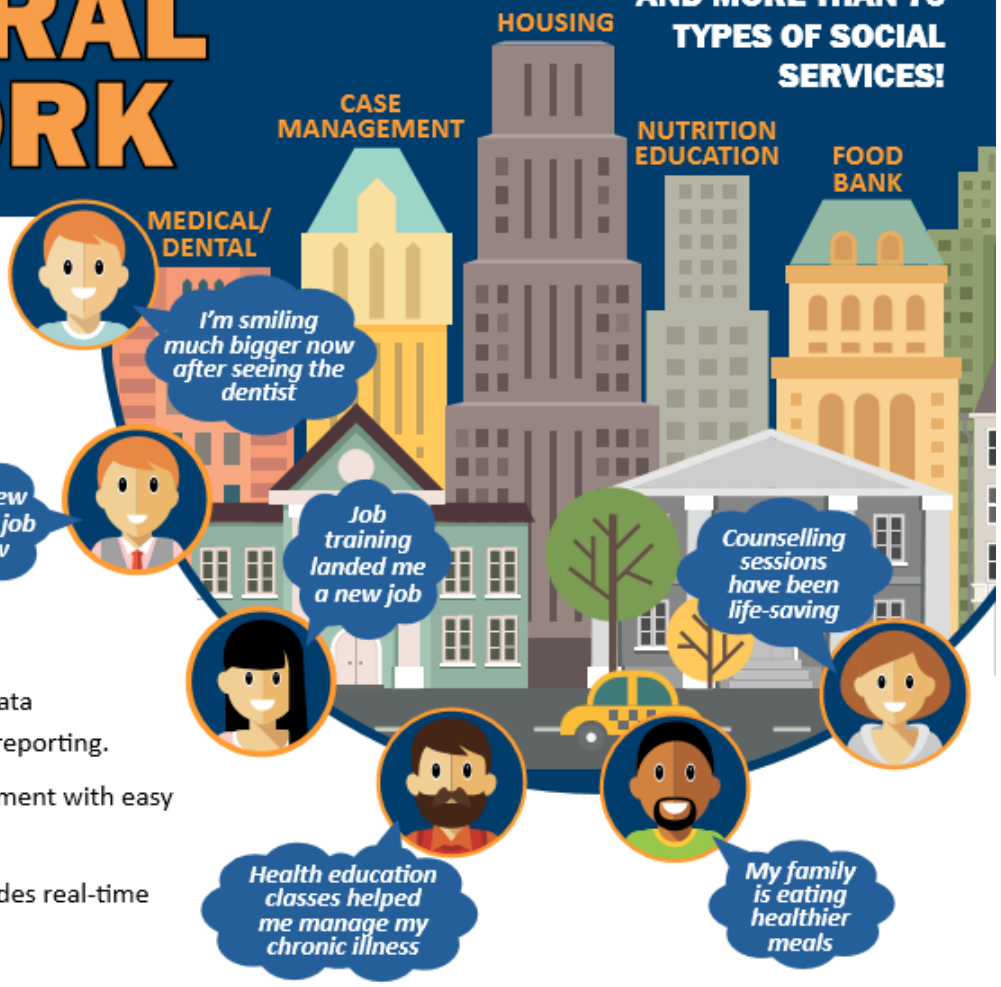
HN Enrollment Summary - OneCare

Health Network Name	OCTOBER 2017	Percentage
Monarch HealthCare (PMG53DE)	734	51.8%
AMVI/Prospect Medical Group (PMG27DE)	323	22.8%
Talbert Medical Group (PMG52DE)	113	8.0%
Family Choice Medical Group (PMG21DE)	91	6.4%
Arta Western Health Network (PMG66DE)	63	4.4%
Alta-Med (PMG69DE)	45	3.2%
United Care Medical Group (PMG67DE)	31	2.2%
Noble Mid Orange County (PMG64DE)	16	1.1%
Total OneCare Enrollment	**1,416**	**100.0%**

Back to Agenda

COMMUNITY REFERRAL NETWORK

FACILITATE REFERRALS FOR MEDICAL, DENTAL AND MORE THAN 75 TYPES OF SOCIAL SERVICES!



An easy-to-use tool that allows organizations to quickly and accurately refer clients for a variety of services in a matter of seconds.

System Benefits Include:

- Comprehensive Client Health Data Management, for tracking and reporting.
- Improved referral case management with easy user interface.
- Fully integrated workflow provides real-time status of each referral.

Back to Agenda

The **Community Referral Network (CRN)** is a web-centric referral system designed to facilitate synergistic relationships with community clinics, hospitals, and social service agencies in order to provide holistic care for their clients. Within the CRN there are five functionalities: eConsult, Specialty Care, Hospital Follow-Up, Surgery Waitlist and Social Services. This slide show will highlight the **Social Services Component**.

OUR MISSION IS TO BRIDGE SERVICE GAPS, CREATE A STRONGER NETWORK OF SERVICES, AND ACHIEVE A HEALTHY, EMPOWERED COMMUNITY. OUR NETWORK WILL CREATE AWARENESS OF UNDERUTILIZED SERVICES THAT ARE AVAILABLE TO UNDERSERVED POPULATIONS.

The program is FREE to use thanks to contributions from:

Kaiser Permanente ❖ St. Joseph Health System ❖ Orange County Community Foundation ❖ United Healthcare

The County of Orange ❖ Coalition of Orange County Community Health Centers ❖ Tides Foundation

Powered by AXEIUM© EHR Community Health built for CHCs ... by CHCs !

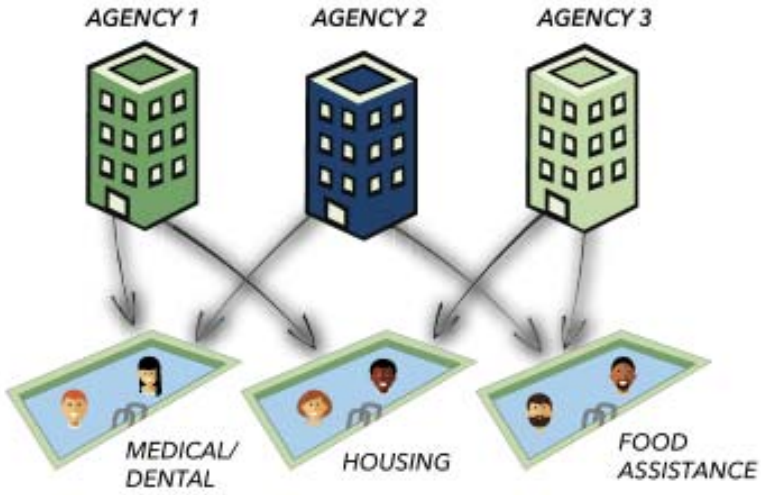
Funded in part by Whole Person Care in partnership with: OC health CARE AGENCY Lestonnac Free Clinic

Back to Agenda

SOCIAL SERVICE REFERRALS

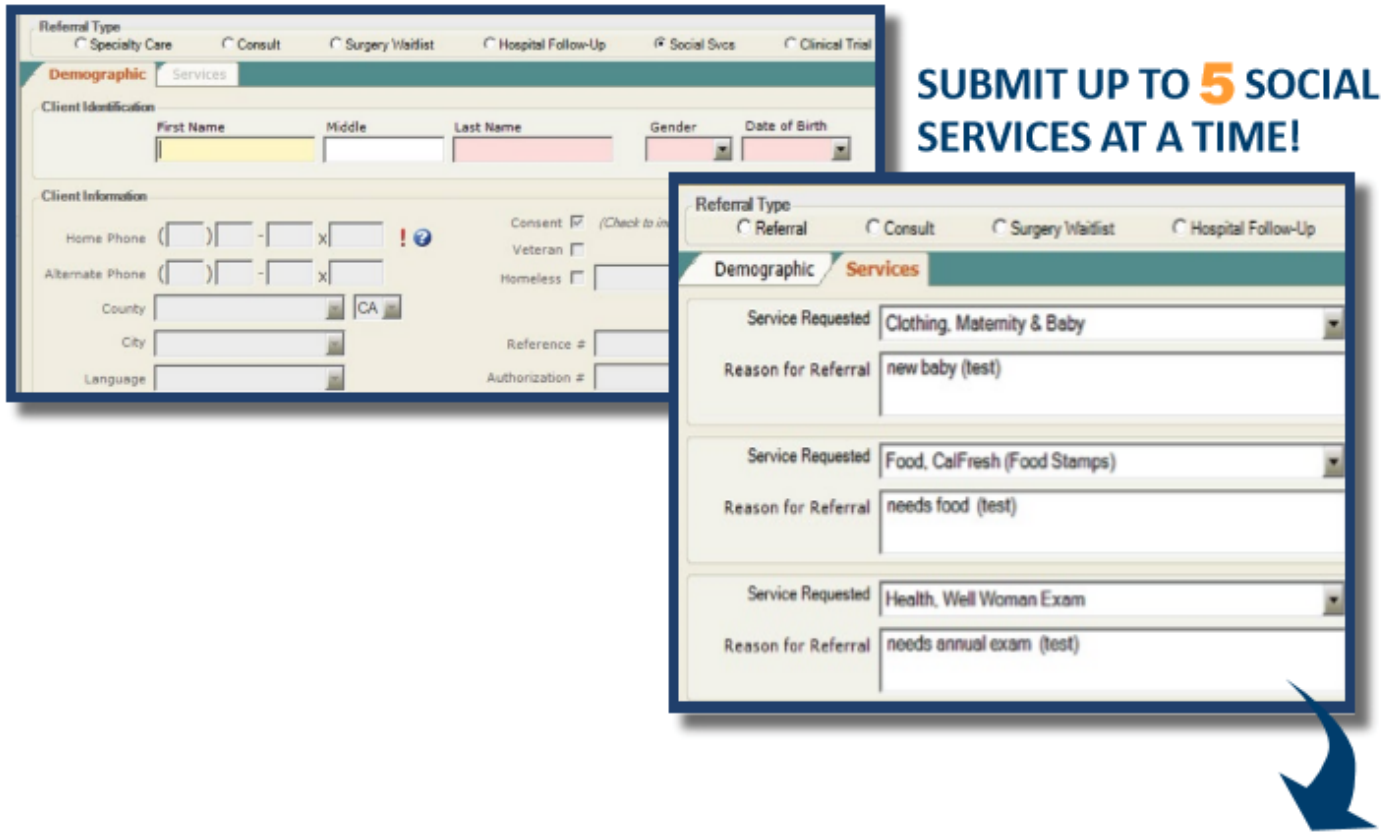
SOCIAL SERVICE POOL

When an agency creates a Social Service Referral, the client is placed in a Service Pool where a corresponding agency in the client's service area may pull the client from the Service Pool to provide them the service they requested.



Back to Agenda

CREATE A REFERRAL
(enter clients into the Service Pool)



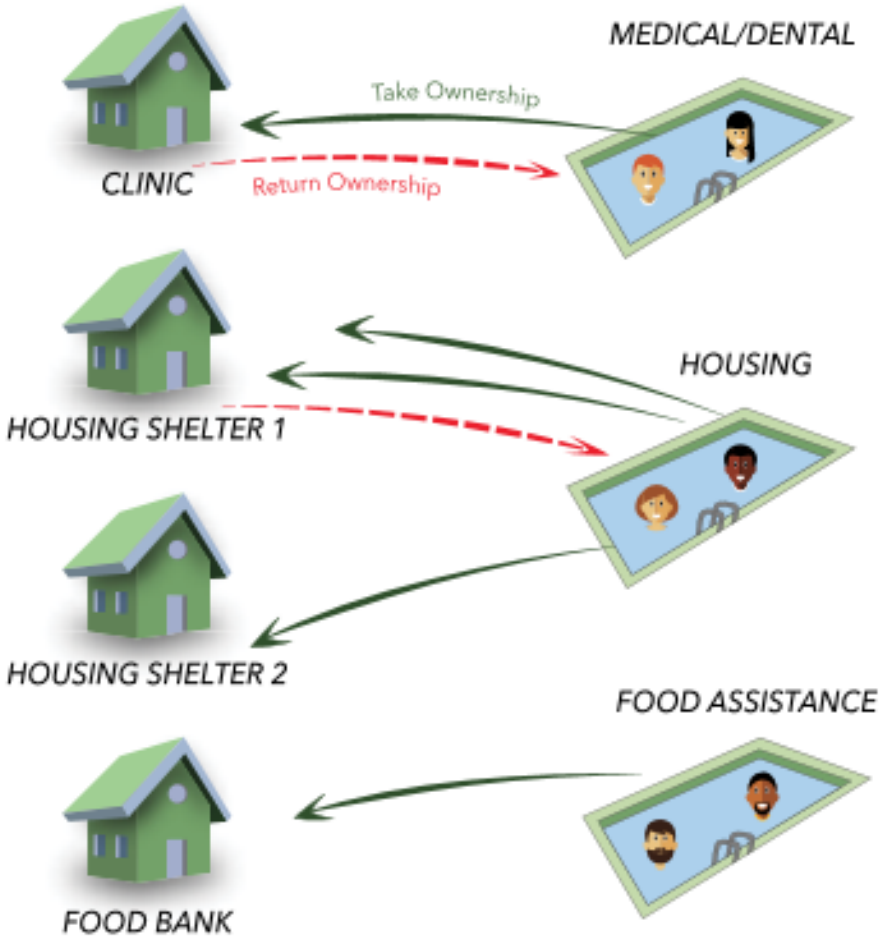
SUBMIT UP TO 5 SOCIAL SERVICES AT A TIME!

[Back to Agenda](#)

RECEIVE A REFERRAL

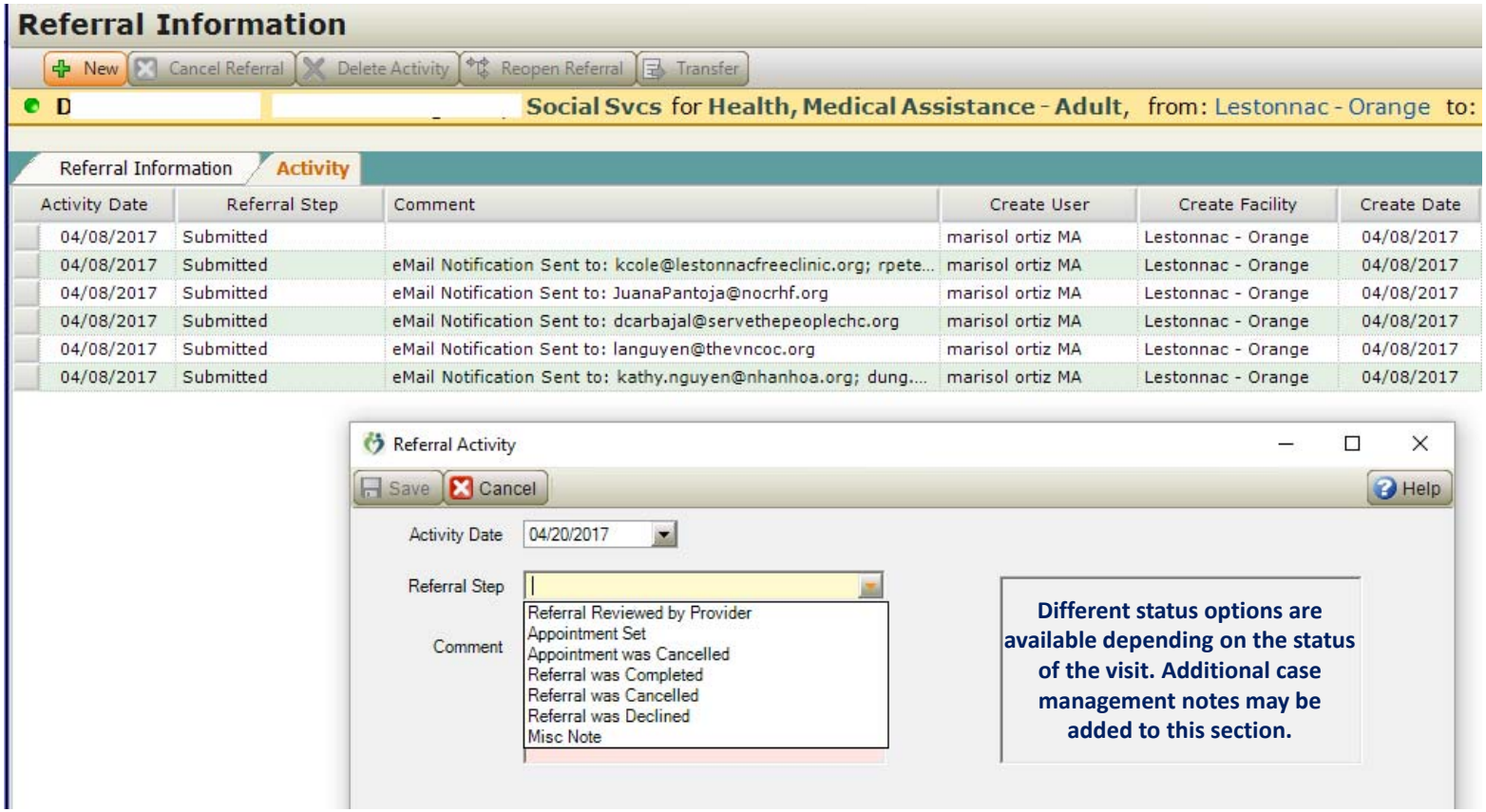
(remove clients from the Service Pool)

In order to Take Ownership of a referral, the agency must pull the client out of the Service Pool. Once that happens, the client will no longer appear in the Service Pool. If for any reason the agency is unable to assist the client, they may Return Ownership therefore sending the client back into the Service Pool for another agency to help.



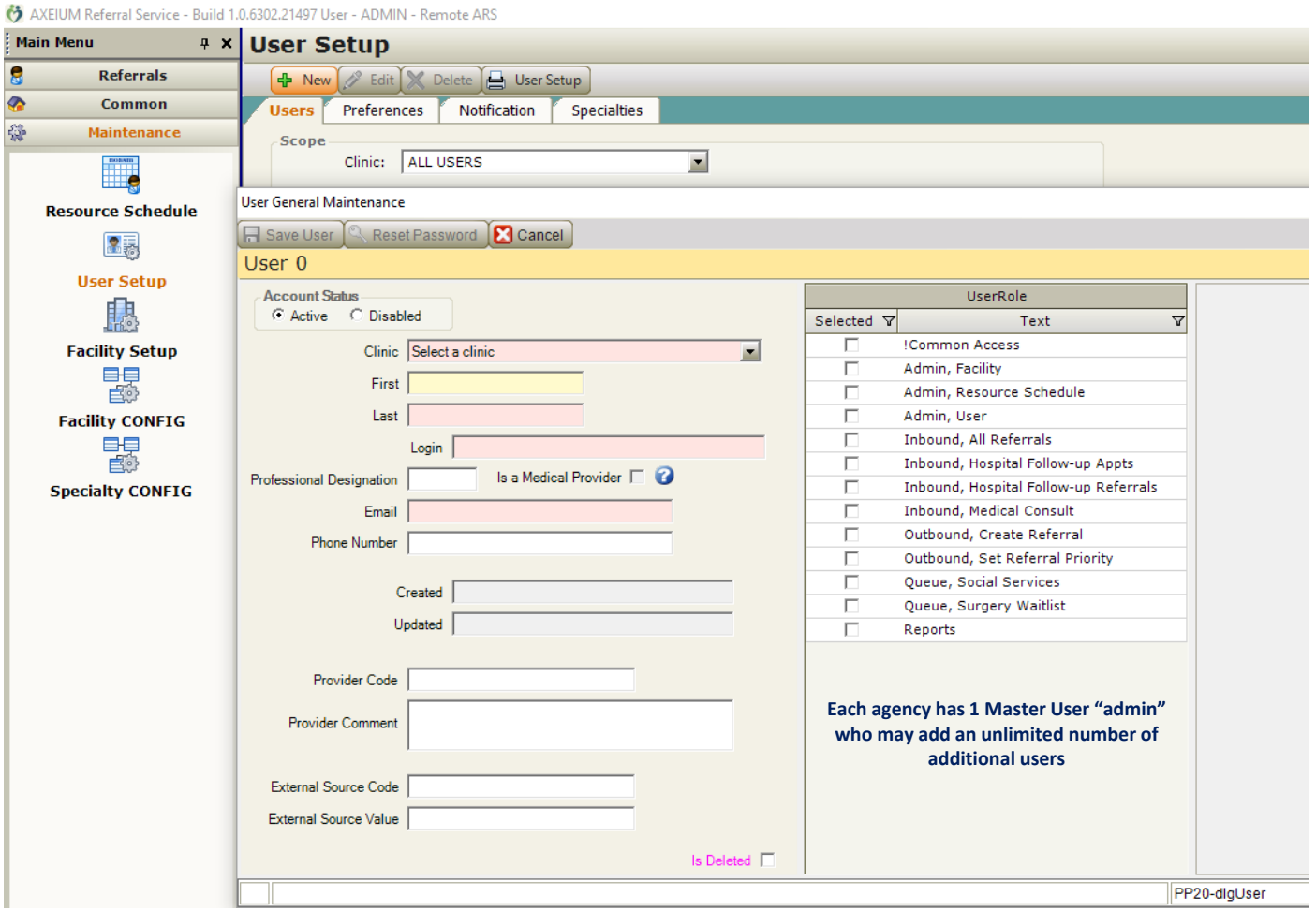
Back to Agenda

Assign Status to Referral to **track results**



Back to Agenda

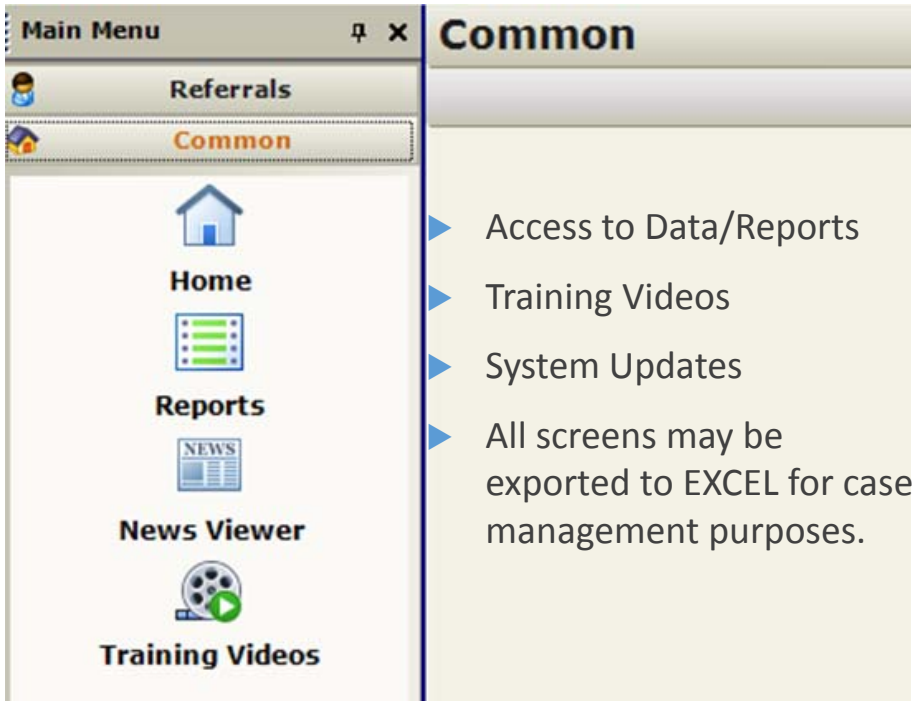
Each Agency may set up an **Unlimited** Number of Users



Back to Agenda

Current Available Services & Additional System Benefits

- **85** Specialty Care Services
- **10** eConsult Services
- **109** Types of Surgeries
- Emergency Room and Discharge Follow Up
- **115** Distinct Social Services
- **110** AGENCIES CURRENTLY IN THE SYSTEM



TO GET STARTED, PLEASE CONTACT: Roseann Peters, Program Manager

Phone: 714.583.6433 ❖ Email: rpeters@lestonnacfreeclinic.org ❖ www.CommunityReferralNetwork.org

Back to Agenda

Palliative Care

Provider Advisory Committee Meeting
November 9, 2017

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

Back to Agenda

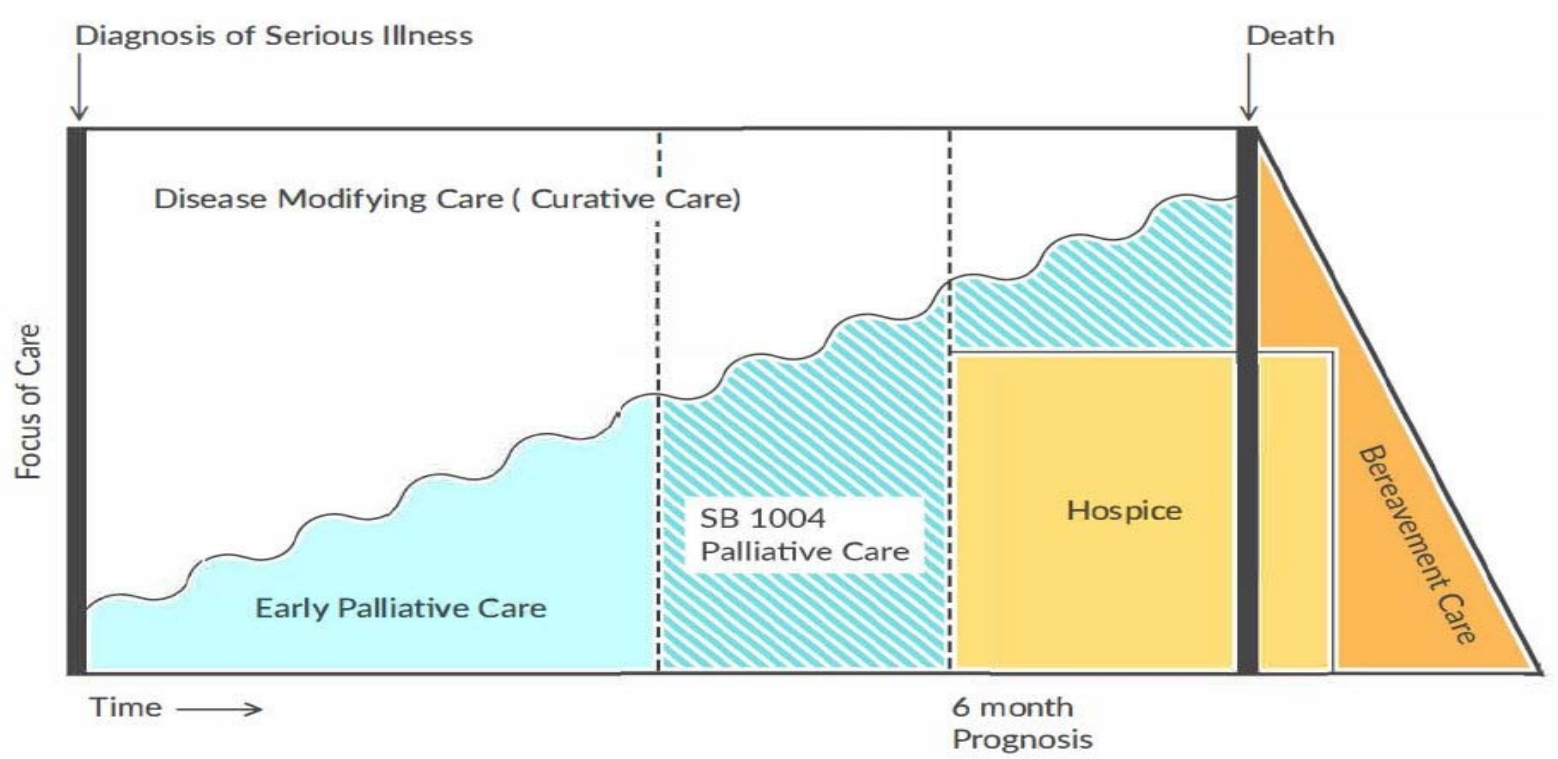
Legislative Background

- Senate Bill 1004 (2014) requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure delivery of palliative care services by Managed Care Plans
- Implementation **no later than 1/1/18**
- DHCS policy document (9/1/16) and final APL (10/19/17) provide guidance for Medi-Cal only members
  - Additional final guidance anticipated before implementation
    - Reporting requirements
    - Quality measures
  - Rate Adjustment not expected

Back to Agenda

Palliative Care Defined

"Patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice." – www.CMS.gov



Back to Agenda

DHCS Palliative Care Goals

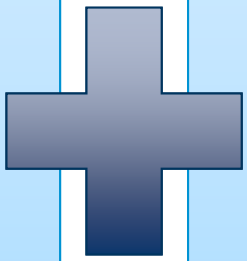
- Optimize member quality of life by anticipating, preventing and treating suffering
- Address physical, intellectual, emotional, social and spiritual needs
- Facilitate patient autonomy, access to information and choice

Back to Agenda

Target Population

General Eligibility Criteria

- Using/likely to use hospital or ED to manage disease
- Advance stage of illness
- Death within 1 year would not be unexpected
- Willing to participate in advanced care planning discussions
- Not eligible for or declines hospice
- Received appropriate desired medical therapy or therapy is not longer effective
- Willing to receive disease management



Has One of Four Diagnoses

- Advanced Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Liver Disease

Notes:

- *Each diagnosis has specific criteria, which may require file review*
- *Plans/HNs may choose to offer Palliative Care based on broader clinical criteria*

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Back to Agenda

CalOptima Direct (COD) Members

- COD Includes CalOptima Community Network (CCN)
  - SB 1004 target population and services at implementation
  - Will contract with providers for service delivery and care coordination
    - Service, reporting and other requirements detailed in P&P being finalized
  - Consider use of Medi-Cal FFS rates
    - Use existing billing codes
    - Potential addition of informational modifiers to distinguish Palliative Care from Hospice
  - Standard provider credentialing criteria based on contracting provider type

Back to Agenda

Health Network (HN) Members

- HNs will be responsible for all SB 1004 Palliative Care services for their assigned members effective 1/1/18
  - CalOptima does not plan to prescribe delivery requirements other than as required in legislation, APL and outlined in CalOptima's policies and procedures
    - Final APL has been provided to HNs for planning purposes
    - CalOptima policy and procedure pending approval from DHCS
  - Reporting will be based on DHCS and plan requirements

Back to Agenda

Next Steps

- Anticipate receipt of DHCS guidance mid-November
  - Reporting requirements
- Receive DHCS approval for CalOptima policies and procedures
- Provide updated guidance and finalized CalOptima policies and procedures to Health Networks
- CalOptima to contract with palliative care providers for CCN/COD members
- Develop reporting metrics per DHCS requirements

Back to Agenda

Resources

- DHCS' Palliative Care website
  - http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

Maternal Mood and Anxiety Disorders

Provider Advisory Committee

Pamela Pimentel, RNC

Chief Executive Officer

Back to Agenda

National and State Data on Maternal Mental Health

The California Task Forces of Status of Maternal Mental Health 2017

- Maternal depression contributes more to unfavorable health outcomes for both mother and baby than any other condition.

- In the spring of 2017, the CDC estimated that more than 20% of all births are negatively impacted by maternal depression and anxiety.

- Low socioeconomic status is the single greatest predictor of maternal depression. The prevalence of maternal depression for mothers at 100% of the FPL soars to over 50%.

- Adverse Childhood Experiences (ACEs) impacts all pregnant and new mothers. But mothers who experienced childhood hardships are disproportionately more likely to experience depressive symptoms during or after pregnancy.

Back to Agenda

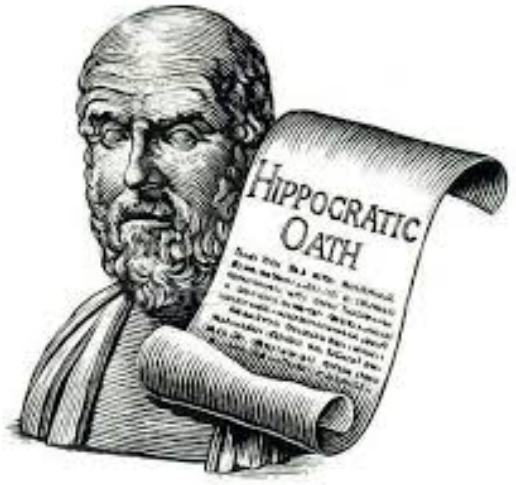
"But Not in Orange County – Right? I never see this in my patients" – *Local OB in 2016*

- Orange County's annual birth rate has leveled out in the past five years – 38,500 births.
- But, what has changed is the increasing number of Orange County births that are Medicaid eligible.
- In 1993, approximately 20% of all Orange County births were Medicaid eligible as compared to 50% of the births today.

Back to Agenda

"Maternal Depression rates are rising because of those Millennials" –*local RN Case Manager Feb. 2017*

The first "medical journal" article was in 700 B.C. by Hippocrates. Not much else was said about Maternal Depression for the next 24 centuries. But <u>why</u> would maternal mental health disappear?



Back to Agenda

“Who gonna worry about mental problems when you gots worry if you or your kids are gonna live or die”

From a pregnant woman in a shelter in the aftermath of Hurricane Katrina.

Back to Agenda

"Death borders upon our birth and our cradle stands in the grave"-- *Joseph Hall, Bishop of Exeter (1801)*

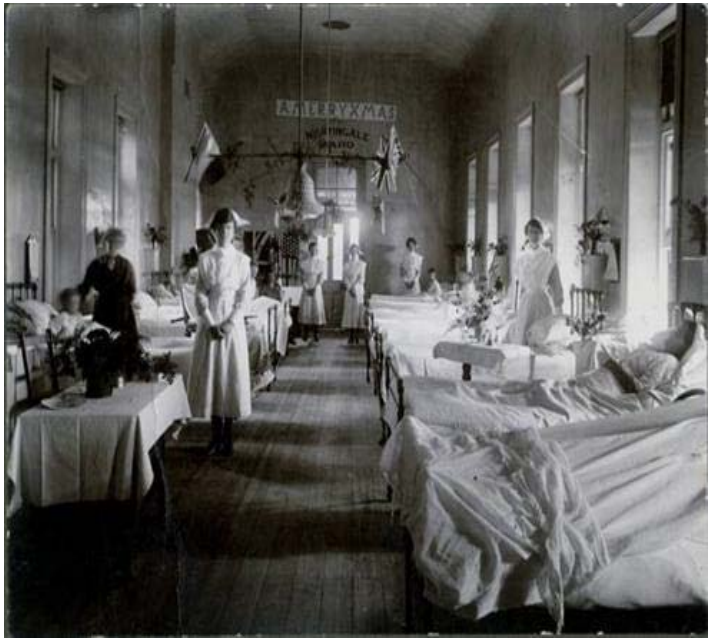
- 60% of women either died in childbirth or within 4 weeks after birth.
- 25% of low income mothers went to insane asylums/ work houses so they could not "pass their insanity to their offspring."
- 40% of higher income mothers were "high strung" and could not breastfeed or care for their infants.

Back to Agenda

The mid-1800's medicine move away from the "spirit realm"

Dr. Louis Pasteur--1847

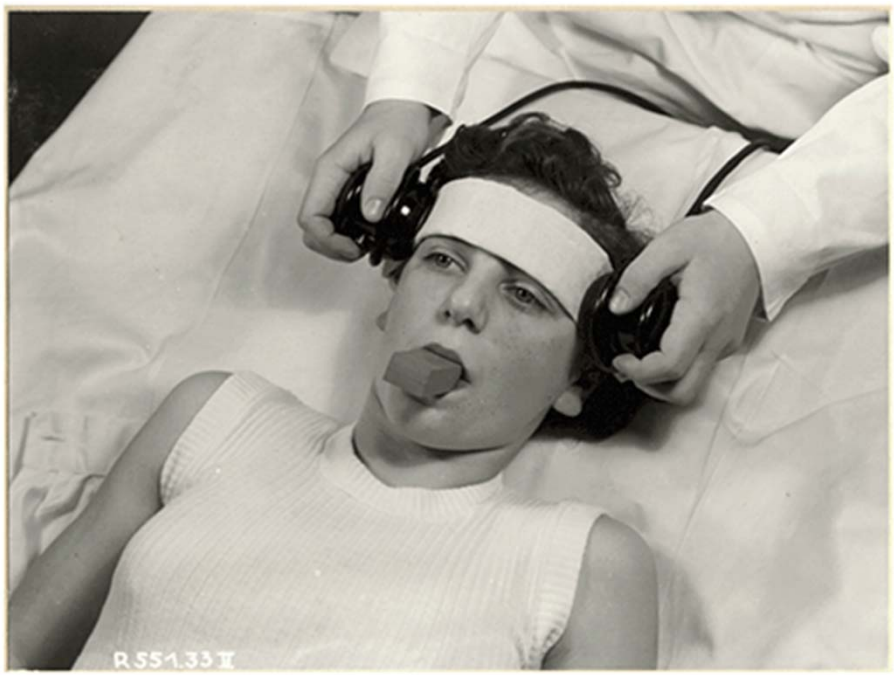
Dr. Semmelwise--1851



Back to Agenda

90 years later, a cure for mental illness

“Then something bent down and took hold of me and shook me like the end of the world [...] with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. I wondered what terrible thing it was that I had done” *Sylvia Plath The Bell Jar (1962)*



Back to Agenda

“Spiritual Guide to Midwifery”-- *Ina May Gaskins, Founder of the Farm Commune in Tennessee*

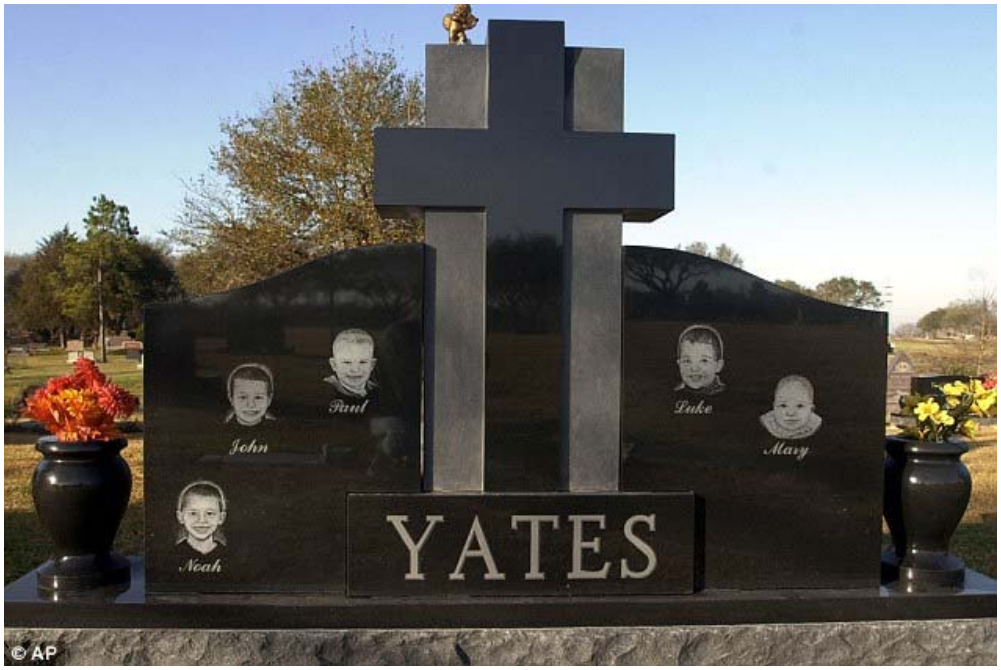
“Like a true Nature’s child, we were born, born to be wild.” Steppenwolf

“This is the dawning of the Age of Aquarius”
The 5th Dimension

Back to Agenda

“The tragedy of the Yates children is one of our greatest failures in our maternal health.”

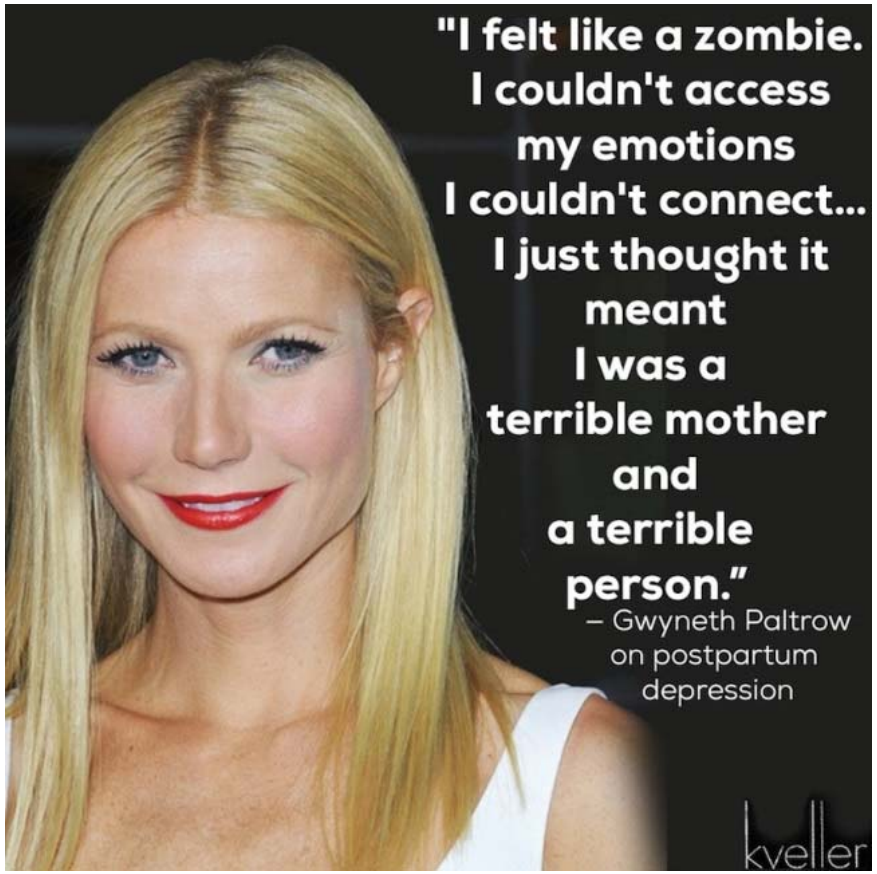
Pamela Pimentel, RN --ABC Nightly News Interview 2002

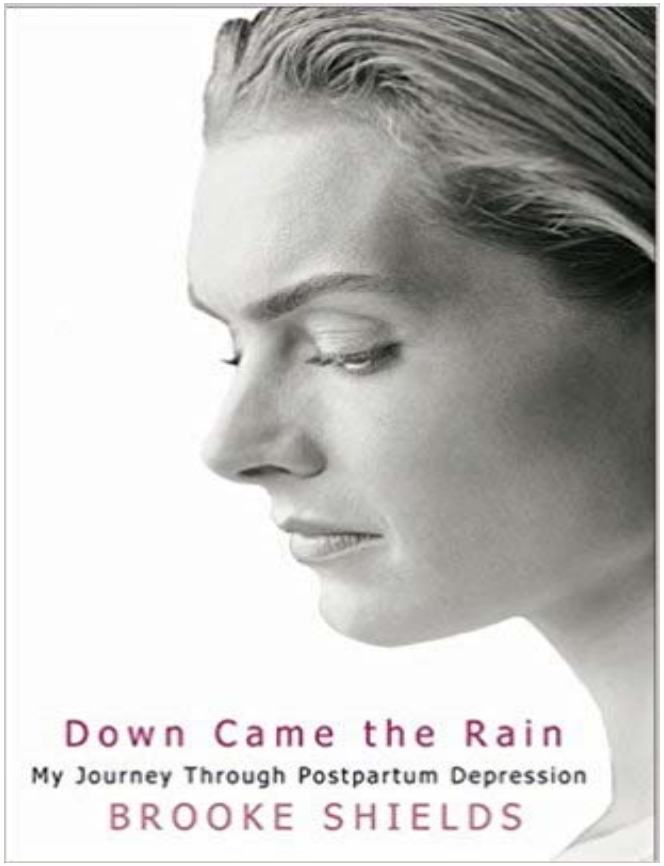


Back to Agenda

“Finally, postpartum depression has come out from the shadows and into the light of day”

Pamela Pimentel Presentation in 2010 at MCH conference





Back to Agenda

So, You May Ask– Where are we now?

In the last 10 years, there has been watershed of research, data, publications, women's stories, documentaries about maternal depression and our society now recognizes that depression is a disease warranting screening, prevention, and treatment

But- has all of this the made a difference? Have we cured maternal depression?

Sort of, maybe, kinda, definitely a good start

Back to Agenda

What is Happening TODAY for the Pregnant and Newly Parenting CalOptima Member who are at-risk for Maternal Mental Health Disorders

- Standardized evidence based too for depression screening risk
- CalOptima's members have mental/behavior health coverage
- Genuine collaboration between HCA, MOMS, CalOptima
- MOMS provided 16,979 Edinburgh Screenings (Q encounter)
- MOMS referred 24% of CalO members to a higher level of service who
- OCPC Grid of Service Providers for mental health

Back to Agenda

2017 and Beyond…

- **Every woman is screened every time for depression risk.**
- **Early intervention and treatment.**
- **No social stigma in any culture.**

Back to Agenda

Celebrating 25 Years

MOMS Orange County

Back to Agenda

CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2017-2018

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 17/18)	Results of PAC Activities for Period
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 establish 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 community and CalOptima using CalOptima's data warehouse	PAC received a comparison study of the Community Network and the delegated Health Networks at the **June** meeting The study included Performance Metrics for Adult & Child Med-Cal Clinical Measures; CAHPS outcomes PAC received Medi-Cal and OneCare HEDIS 2017 results for 2016 data at the **August** meeting OneCare Connect baseline results were also presented Next steps were discussed to implement strategies of low performing results	**The Health Networks and CalOptima created a work group to review data and identify gaps in data.**
		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	1) Regular updates have been presented at all PAC meetings At the **Sept** joint MAC/PAC meeting Michael Schrader provided us an update on the status to move the administrative services from Magellan to CalOptima effective 1/1/18 2) WPC update was presented to the PAC at the August meeting The start date was July 1st	**PAC members will provide feedback to CalOptima staff regarding the transition of behavioral health services for the Medi-Cal members (mild to moderate).**
		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	At the **August** PAC meeting staff presented the status of the IGT the approved IGT funding categories for IGT 6&7 The PAC was also provided a status on IGT funding for 1-5	**PAC members will solicit feedback from their consituents for potential future IGT projects. Discuss in Q2.**

Back to Agenda

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CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 17/18)	Results of PAC Activities for Period
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	1) CalOptima implemented EFT funds transfer for capitation payment for the health networks (Medi-Cal and the Medi-Cal payment for OneCare Connect) Future cap payments for OneCare and OneCare Connect will be implemented 2) Data exchange processes were simplified from excel file format to XLM This will allow CalOptima to pull data directly instead of asking the delegated health networks for the same data 3) Predictive modeling - presentation	**Request Predictive modeling presentation in Q2.**
		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 establish 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		**CalOptima will continue to provide reports for discussion by PAC.**

Back to Agenda

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GOALS AND OBJECTIVES FY 2017-2018

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 17/18)	Results of PAC Activities for Period
		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		**Request agenda item in Q2.**

Back to Agenda

CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2017-2018

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 17/18)	Results of PAC Activities for Period
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 improve service to providers and members, expand access, and advance shared health priorities.**	Provide timely input on key issues prior to Board decision	This issue was identified to be discussed at the joint MAC/PAC September meeting, however we ran out of time This will be discussed at a future joint meeting or a regular meeting of the PAC	**CalOptima will continue to provide reports for discussion by PAC.**
		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		
		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	PAC received Medi-Cal and OneCare HEDIS 2017 results for 2016 data at the August meeting OneCare Connect baseline results were also presented Next steps were discussed to implement strategies of low performing results	**CalOptima will continue to provide reports for discussion by PAC.**

Back to Agenda

CalOptima Board of Directors'
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GOALS AND OBJECTIVES FY 2017-2018

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 17/18)	Results of PAC Activities for Period
III. Partnership and Engagement (Cont.)	**Engage providers and community partners in improving the health status and experience of our members (Cont.)**	**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	CalOptima informed members to utilize our associatations (CAPG, HASC etc) to help develop awareness for the continuation of the SNP, Cal MediConnect and Medi-Cal programs with the State Discussions should include the Medi-Cal Expansion and Classic rates	**Request agenda item in Q2.**
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					

Back to Agenda