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

THURSDAY, MAY 10, 2018
8:00 A.M.

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

AGENDA

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

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

I. CALL TO ORDER
Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES
A. Approve Minutes of the April 12, 2018 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 Fiscal Year (FY) 2018-19 PAC Meeting Schedule
B. Consider Approval of FY 2017-2018 PAC Accomplishments
C. Consider Recommendation of PAC Slate of Candidates, and Chair and Vice Chair for FY 2018-19

VI. CEO AND MANAGEMENT REPORTS

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

VII. INFORMATION ITEMS

A. Intergovernmental Transfer (IGT) Funds Update
B. Health Homes Program Update
C. Appropriate Use of Emergency Room Services
D. PAC Goals and Objectives
E. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

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MINUTES

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

April 12, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, April 12, 2018, 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 8:06 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; John Nishimoto, O.D; Mary Pham, Pharm.D., CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	George Orras, Ph.D., FAAP; Suzanne Richards, MBA, FACHE, Vice Chair;
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Michelle Laughlin, Executive Director, Network Operations; Nancy Huang, Controller; Cheryl Simmons, Staff to the PAC

Chair Miranti announced that Mary Hale, Orange County Health Care Agency (OCHCA) Representative, has retired from the OCHCA.

MINUTES

Approve the Minutes of the February 8, 2018 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 8, 2018 meeting. (Motion carried 12-0-0; Vice Chair Richards and Member Orras absent)***

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Approve the Minutes of the March 8, 2018 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect MAC and Provider Advisory Committees

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the minutes of the March 8, 2018 Joint Meeting. (Motion carried 12-0-0; Vice Chair Richards and Member Orras absent)***

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, referred PAC members to the CEO report included in the meeting materials.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided updates to several ongoing items. She noted that Behavioral Health Treatment Services were transferring from the Regional Center of Orange County (RCOC) effective July 1, 2018. Ms. Khamseh also discussed the timeline associated with the Whole Child Model (WCM), and the transition of the Child Health and Disability Prevention Program (CHDP) claim forms and the delegation of payment to the health networks. She noted that the Department of Healthcare Services changed the start date of the Health Homes Program from January 1, 2019 to July 1, 2019. Ms. Khamseh updated the PAC on anticipated additional Proposition 56 (Tobacco tax) funds and also mentioned that Medicare has begun to issue the new Medicare identification cards, which removes the member's social security number and replaces it with a new identification number.

Chief Financial Officer Update

Nancy Huang, Controller, presented the February 2018 financial report, and summarized CalOptima's financial performance and current reserve levels. Ms. Huang also provided a 2018-19 budget briefing and noted that the final budget would be presented to the Board at the June 7, 2018 meeting for their approval.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, introduced Jennifer Bamberg as the new Director of Provider Relations. Ms. Laughlin shared the new Medicaid enrollment flier that has been developed and will be sent to all providers who are not registered in the State's Medi-Cal program. The flier informs providers about the new rule imposed by the Centers for Medicare & Medicaid Services (CMS) that all provider applications must be completed and submitted by the December 31, 2018 deadline to CMS. Ms. Laughlin also discussed the CCS transition to CalOptima. It was noted that discussions continue with the State concerning rates. It is anticipated that additional information will be provided at the May 10, 2018 PAC meeting.

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INFORMATION ITEMS

Strategic Plan Update
Michael Schrader, Chief Executive Officer, presented an update on CalOptima's 2017-2019 Strategic Plan. There was much discussion centered on the Intergovernmental Transfer (IGT) funds and the programs attributed to the various IGTs, in particular, IGTs 5, 6 and 7. Mr. Schrader reported that a Request for Information (RFI) would be sent out with the next week or two to identify the best use of IGT 5 funds for mental health purposes.

Joint MAC/OCC MAC and PAC Meeting Debrief
This agenda item was moved to the May PAC meeting.

PAC Goals and Objectives
Chair Miranti asked the committee to review the Goals and Objectives for the second quarter and let Staff know if they had any suggested changes.

PAC Member Updates
Chair Miranti noted that the PAC Nominations Ad Hoc Committee would be meeting on April 18, 2018 to review the candidates for the open PAC seats.

ADJOURNMENT
There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:59 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: May 10, 2018

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Provider Advisory Committee
FY 2018-2019 Meeting Schedule

July
Thursday, July 12, 2018
No Meeting

August
Thursday, August 9, 2018

September
Thursday, September 13, 2018

October
Thursday, October 11, 2018

November
Thursday, November 8, 2018

December
Thursday, December 13, 2018

January
Thursday, January 10, 2019
No Meeting

February
Thursday, February 14, 2019

March
Thursday, March 14, 2019

April
Thursday, April 11, 2019

May
Thursday, May 9, 2019

June
Thursday, June 13, 2019

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.

All meetings are open to the public. Interested parties are encouraged to attend.

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Provider Advisory Committee
FY 2017 - 2018 Accomplishments

During FY 2017-2018 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:

- The PAC Allied Health Representative helped to recruit two new Member Advisory Committee (MAC) members during FY2017-2018 who were approved by the Board. Member also assisted in the recruitment of two more possible representatives, one for Family Whole Child Advisory Committee member and an applicant for MAC. Member assisted with the Member Needs Assessment Survey by being a key informant and allowing CalOptima to use MOMs facility for the focus group meetings. MOMs staff assisted with the recruitment of the members MOMs serves for their participation and feedback.

- 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 2017–2018.

- 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.

- 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.

- PAC Health Network Representative shared information with all the health networks at the monthly Health Network Forum. She gathered feedback from them on topics to bring forward for discussion. Topics included: rate discussions, IGT funding, difficult to access providers, transgender services, Prop 56 and Opioid Epidemic.

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- All PAC members completed the annual Compliance Training for 2017/18 by the deadline.

- PAC held a total of two joint meetings during the 2017-18. The first meeting was a MAC/PAC meeting and was held on September 14, 2018 and the second meeting was held March 8, 2018 with MAC and OCC MAC. PAC hopes to continue to share feedback with the other advisory committees on a yearly basis.

- 2018 PAC Nomination Ad Hoc subcommittee met on April 18, 2018, to select new PAC members for the four PAC vacancies: Allied Health, Behavioral Health, Health Network, and Nurse Representatives. The ad hoc members presented the slate of candidates to the full PAC on May 10, 2018 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 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.

- The PAC Chair solicited discussion topics/presentations from other PAC members which led to sharing their expertise about programs we were not aware of. The Chair monitored and documented the quarterly PAC Goals and Objectives. As Chair she spent on average three hours a month working with staff to the PAC to formalize the agenda and review and edit PAC's Report to the Board. The Chair worked with CalOptima staff to review the Member Needs Assessment report. As the Chair, she discussed issues with other committee members to ensure their concerns were addressed at a PAC meeting.

- PAC members attendance equals on average over 82% of members attending each monthly meeting and there are 12 out of 15 members attending each meeting.

- In addition to meeting monthly during FY 2017-18, PAC members have participated in at least five (5) ad hoc subcommittees and dedicated approximately 403 hours or the equivalent of 50 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.

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MEMORANDUM

DATE:	May 3, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Program of All-Inclusive Care for the Elderly (PACE) Expansion Now Operational
Months in the making, the expansion of CalOptima PACE has officially begun. In April, the first PACE participant began receiving regular services at Acacia Adult Day Services, the first of five Alternative Care Setting sites that will be brought on as CalOptima PACE enhances its reach and capacity. Further, this month, PACE will identify its first community-based physician, with a plan to contract in June and have the physician as part of a care team by July. This flexibility to include doctors other than the PACE physician follows CalOptima's recently approved federal waiver, which allows participants to continue receiving care from the community-based physicians they have known for years. Finally, next up is PACE Service Area Expansion. In July, CalOptima PACE can begin serving participants in all Orange County ZIP codes, offering access to comprehensive, coordinated care without limitations because of where eligible participants live. I look forward to providing updates regarding this exciting time in the history of CalOptima PACE.

Centers for Medicare & Medicaid Services (CMS) Conducts Routine PACE Audit
As another sign of CalOptima PACE's maturity, the program underwent its first standard CMS audit in late April. This was the first audit conducted since the conclusion of the CMS three-year trial period, during which time the new program was audited annually with generally positive results. The standard audit protocol measures CalOptima PACE's performance in both clinical and administrative areas. Regulators will provide feedback during an exit conference planned for early May.

Budget for New Fiscal Year Highlights Key Changes, Challenges
As a public agency, CalOptima is focused on prudent use of resources and financial transparency. Those goals were the impetus behind the introduction to the FY 2018–19 CalOptima budget, shared at the April Board meeting. One potentially significant budget issue is the possible change in rates for Medi-Cal Expansion members, bringing them closer to the rates paid for Medi-Cal Classic members. Over the past few months, we have made this possible rate change clear to health networks and providers so they can plan ahead. Also significant is CalOptima's January 2019 integration of California Children's Services as part of the Whole-Child Model. The state is developing a per member per month rate for CCS services, which will be part of CalOptima's budget for next year.

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Medical Loss Ratio (MLR) Audit Shows Aggregate Health Network Spending at 91 Percent
To measure medical spending in the Medi-Cal Expansion era, CalOptima is in the process of completing an MLR audit of our contracted health networks. The purpose of the audit is to ensure that an appropriate portion of health networks' capitation payments is used to pay for medical services. Under contract, health networks are obligated to spend 85 percent or more of their capitation revenue on member health expenses. Based on preliminary analysis, the aggregate MLR for all health networks is 91 percent, which is good news showing that networks took less than the maximum of 15 percent for administrative costs and profit. To be abundantly fair with our MLR methodology, CalOptima aggregated results for Medicare and Medi-Cal Classic and Expansion members, since health networks could have margins far smaller than 15 percent for Classic and greater than 15 percent for Expansion. Further, we combined the first three years of Classic and Expansion (2014, 2015 and 2016) since the rates for Expansion have decreased over time. The initial findings show that health networks are appropriately passing dollars along to providers. However, there are a few networks that did have lower than required medical spending. Our compliance team will oversee corrective action so these networks distribute at least 85 percent to the provider community and establish new operating parameters, ensuring the ratio is met both during the audit period and in the future. Going forward, CalOptima plans to conduct MLR audits of the networks on an annual basis.

CalOptima Readies for Another Transition of Behavioral Health Treatment (BHT)
In another vote of confidence about managed care plans' ability to handle behavioral health, the Department of Health Care Services (DHCS) released a timeline for the transition of BHT for children with non-Autism Spectrum Disorders. Responsibility for those services is moving from Regional Centers to Medi-Cal managed care plans, including CalOptima, starting in July 2018. (CalOptima completed a similar transition for the population with Autism Spectrum Disorders about two years ago.) Orange County will follow a phased approach based on birth month. The first group of birthdays (January–April) will transition July 1, and two other birthday groups will move August 1 and September 1. CalOptima is responsible for mailing 60- and 30-day notices to ensure those affected are aware in advance.

CalOptima Providers to Enroll in Medi-Cal Based on New Mega Reg Rule
Based on rules in the federal Mega Reg, DHCS issued an All-Plan Letter late last year stating that all Medi-Cal contracted providers are required to be enrolled with Medi-Cal. Effective January 1, 2018, all non-contracted providers who want to participate with CalOptima must first be enrolled with Medi-Cal, and any contracted providers who are not currently enrolled have until December 31, 2018, to become enrolled or face possible contract termination. CalOptima's policy has always required provider enrollment in Medi-Cal, yet we have made careful exceptions when there was a need for a certain type of provider or specialist. In March, CalOptima notified those who need to enroll, sending approximately 1,200 letters to various providers affiliated with CalOptima Community Network, health networks, behavioral health vendors or ancillary services companies.

Board Ad Hoc Committee Considers Appropriate Timing for Community Grants
CalOptima's Intergovernmental Transfer (IGT) Ad Hoc committee of the Board was reconfigured in April to guide the community grant process for projects in three approved

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categories: opioid and other substance overuse, children's mental health, and homeless health. The group is also considering these grants in light of Orange County's highly visible, multifaceted effort to address the homeless crisis in our community. At a recent meeting, the Ad Hoc committee determined that CalOptima needs more time to engage with those working on the homeless issue to better understand the needs of the population and to plan next steps before releasing limited grant dollars. Community organizations that submitted Letters of Interest seeking grants to fund programs and services in the three categories will be informed about changes to the timeline.

CalOptima Maintains Full Calendar of Community Activities

Reflecting dedication to external outreach and engagement, CalOptima participates in a variety of activities, ranging from events, meetings and media appearances, to ensure that stakeholders remain aware of our commitment to Orange County. Here are selected items from April:

- **South County Senior Summit**
  I spoke at the South County Senior Summit when CalOptima was recognized as the event's diamond sponsor. Hosted by Supervisor Lisa Bartlett, the event shares important health information and community resources with seniors. CalOptima had a booth to highlight our PACE program.
- **Whole-Child Model Outreach**
  In our industry-leading effort to raise awareness about the move of California Children's Services to the Whole-Child Model, CalOptima executives overseeing the transition spoke to physicians at three separate events, including a dinner meeting with the Orange County Medical Association's Pediatric Committee and two pediatrician meetings for HealthCare Partners. More outreach to physicians, member advocates and affected families is planned in the coming months.
- **Vietnamese Radio**
  CalOptima's OneCare/OneCare Connect Customer Service Supervisor, Tammy Nguyen, spoke in Vietnamese during an evening interview on VietLink Radio 1480 AM. The 30-minute show covered CalOptima services, local resources at the County Community Service Center and a PACE update.

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Financial Summary

March 2018

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- March 2018 MTD:
  - Overall enrollment was 788,700 member months
    - Actual lower than budget by 15,595 or 1.9%
      - Medi-Cal: unfavorable variance of 14,715 members
        - TANF unfavorable variance of 15,794 members
        - SPD unfavorable variance of 3,191 members
        - Medi-Cal Expansion (MCE) favorable variance of 4,082 members
        - Long-Term Care (LTC) favorable variance of 188 members
      - OneCare Connect: unfavorable variance of 819 members
    - 5,878 decrease from prior month
      - Medi-Cal: decrease of 5,742 from February
      - OneCare Connect: decrease of 143 from February
      - OneCare: increase of 1 from February
      - PACE: increase of 6 from February

FY 2017-18: Consolidated Enrollment

- March 2018 YTD:
  - Overall enrollment was 7,117,159 member months
    - Actual lower than budget by 110,003 or 1.5%
      - Medi-Cal: unfavorable variance of 106,465 members or 1.5%
        - TANF unfavorable variance of 118,062 members
        - SPD unfavorable variance of 13,830 members
        - MCE favorable variance of 23,849 members
        - LTC favorable variance of 1,578 members
      - OneCare Connect: unfavorable variance of 3,628 members or 2.6%
      - OneCare: favorable variance of 123 members or 1.0%
      - PACE: unfavorable variance of 33 members or 1.6%

FY 2017-18: Consolidated Revenues

- March 2018 MTD:
  - ➢ Actual higher than budget by $2.5 million or 1.0%
    - Medi-Cal: unfavorable to budget by $2.2 million or 1.0%
      - Unfavorable volume variance of $4.3 million
      - Favorable price variance of $2.1 million due to:
        - ➢ $2.8 million of FY18 Applied Behavior Analysis (ABA) revenue
        - ➢ $3.5 million of FY18 non-LTC revenue
        - ➢ ($1.7) million of FY18 Hepatitis C revenue
        - ➢ ($1.5) million of FY18 Coordinated Care Initiative (CCI) revenue
        - ➢ ($1.3) million of prior year CCI and non-LTC revenue

FY 2017-18: Consolidated Revenues (cont.)

- March 2018 MTD:
  - OneCare Connect: favorable to budget by $4.5 million or 17.7%
    - Unfavorable volume variance of $1.3 million due to lower enrollment
    - Favorable price variance of $5.8 million due to FY18 and prior year rate adjustment
  - OneCare: favorable to budget by $127.9 thousand or 8.6%
    - Unfavorable volume variance of $59.9 thousand
    - Favorable price variance of $187.8 thousand due to rate increase
  - PACE: favorable to budget by $88.5 thousand or 5.1%
    - Unfavorable volume variance of $33.8 thousand
    - Favorable price variance of $122.3 thousand

FY 2017-18: Consolidated Revenues (cont.)

- March 2018 YTD:
  - Actual higher than budget by $75.4 million or 3.1%
    - Medi-Cal: favorable to budget by $59.7 million or 2.8%
      - Unfavorable volume variance of $32.4 million
      - Favorable price variance of $92.1 million due to:
        - $32.2 million of FY18 In-Home Supportive Services (IHSS) Dual and Non-Dual revenue
        - $27.2 million of LTC revenue from Non-LTC
        - $27.1 million of ABA revenue
        - $17.2 million of prior year CCI and IHSS revenue
        - $6.2 million due to release of prior year reserve offset by:
        - ($12.0) million of Hepatitis C revenue
        - ($5.3) million due to true up of prior year rates

FY 2017-18: Consolidated Revenues (cont.)

- March 2018 YTD:
  - OneCare Connect: favorable to budget by $15.9 million or 6.6%
    - Unfavorable volume variance of $6.2 million
    - Favorable price variance of $22.1 million due to 15% rate increase
  - OneCare: Unfavorable to budget by $1.0 million or 8.3%
    - Favorable volume variance of $0.1 million
    - Unfavorable price variance of $1.2 million
      - Due to Part D and Hierarchical Condition Category (HCC) reconciliation
  - PACE: favorable to budget by $0.8 million or 5.7%
    - Unfavorable volume variance of $0.2 million
    - Favorable price variance of $1.0 million due to Part D true-up

FY 2017-18: Consolidated Medical Expenses

- March 2018 MTD:
  - ➢ Actual higher than budget by $4.7 million or 1.9%
    - Medi-Cal: favorable variance of $0.8 million
      - Favorable volume variance of $4.2 million
      - Unfavorable price variance of $3.3 million
        - ➢ Professional Claims unfavorable variance of $9.6 million due to Behavioral Health Treatment (BHT) expenses of $5.6 million, crossover expenses of $1.7 million and claim expenses of $2.0 million
        - ➢ Managed Long-Term Services and Support (MLTSS) unfavorable variance of $4.0 million due to LTC expenses
        - ➢ Facilities favorable variance of $8.4 million due Shared Risk release
    - OneCare Connect: unfavorable variance of $5.3 million
      - Favorable volume variance of $1.3 million
      - Unfavorable price variance of $6.6 million

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

- March 2018 YTD:
  - Actual higher than budget by $95.7 million or 4.1%
    - Medi-Cal: unfavorable variance of $86.0 million
      - Favorable volume variance of $31.0 million
      - Unfavorable price variance of $117.0 million
        - MLTSS expenses unfavorable variance of $53.6 million
        - Professional Claims expenses unfavorable variance of $39.6 million
        - Provider Capitation expenses unfavorable variance of $21.8 million
    - OneCare Connect: unfavorable variance of $11.6 million
      - Favorable volume variance of $5.8 million
      - Unfavorable price variance of $17.4 million
- Medical Loss Ratio (MLR):
  - March 2018 MTD: Actual: 98.4% Budget: 97.5%
  - March 2018 YTD: Actual: 96.4% Budget: 95.5%

FY 2017-18: Consolidated Administrative Expenses

- March 2018 MTD:
  - Actual lower than budget by $1.8 million or 14.6%
    - Salaries, wages and benefits: favorable variance of $0.9 million
    - Purchased Services: favorable variance of $0.5 million
    - Other categories: favorable variance of $0.4 million

- March 2018 YTD:
  - Actual lower than budget by $22.1 million or 20.1%
    - Purchased Services: favorable variance of $8.9 million
    - Salaries, wages and benefits: favorable variance of $6.9 million
    - Other categories: favorable variance of $6.2 million

- Administrative Loss Ratio (ALR):
  - March 2018 MTD: Actual: 4.0% Budget: 4.7%
  - March 2018 YTD: Actual: 3.5% Budget: 4.5%

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FY 2017-18: Change in Net Assets

- March 2018 MTD:
  - $3.8 million deficit
  - $1.7 million favorable to budget
    - Higher than budgeted revenue of $2.5 million
    - Higher than budgeted medical expenses of $4.7 million
    - Lower than budgeted administrative expenses of $1.8 million
    - Higher than budgeted investment and other income of $2.1 million

- March 2018 YTD:
  - $15.5 million surplus
  - $13.2 million favorable to budget
    - Higher than budgeted revenue of $75.4 million
    - Higher than budgeted medical expenses of $95.7 million
    - Lower than budgeted administrative expenses of $22.1 million
    - Higher than budgeted investment and other income of $11.4 million

Enrollment Summary: March 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
63,303	64,963	(1,660)	(2.6%)	Aged	569,198	570,666	(1,468)	(0.3%)
621	618	3	0.5%	BCCTP	5,513	5,562	(49)	(0.9%)
47,281	48,815	(1,534)	(3.1%)	Disabled	426,732	439,045	(12,313)	(2.8%)
320,242	328,966	(8,724)	(2.7%)	TANF Child	2,893,897	2,965,581	(71,684)	(2.4%)
96,404	103,474	(7,070)	(6.8%)	TANF Adult	887,533	933,911	(46,378)	(5.0%)
3,456	3,268	188	5.8%	LTC	30,990	29,412	1,578	5.4%
241,014	236,932	4,082	1.7%	MCE	2,152,615	2,128,766	23,849	1.1%
772,321	**787,036**	**(14,715)**	**(1.9%)**	**Medi-Cal**	**6,966,478**	**7,072,943**	**(106,465)**	**(1.5%)**
14,793	**15,612**	**(819)**	**(5.2%)**	**OneCare Connect**	**136,288**	**139,916**	**(3,628)**	**(2.6%)**
251	**256**	**(5)**	**(2.0%)**	**PACE**	**2,091**	**2,124**	**(33)**	**(1.6%)**
1,335	**1,391**	**(56)**	**(4.0%)**	**OneCare**	**12,302**	**12,179**	**123**	**1.0%**
788,700	**804,295**	**(15,595)**	**(1.9%)**	**CalOptima Total**	**7,117,159**	**7,227,162**	**(110,003)**	**(1.5%)**

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Financial Highlights: March 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
788,700	804,295	(15,595)	(1.9%)	Member Months	7,117,159	7,227,162	(110,003)	(1.5%)
258,436,980	255,949,681	2,487,299	1.0%	Revenues	2,494,742,075	2,419,345,071	75,397,004	3.1%
254,187,988	249,492,168	(4,695,820)	(1.9%)	Medical Expenses	2,404,937,520	2,309,268,775	(95,668,745)	(4.1%)
10,375,773	12,148,518	1,772,744	14.6%	Administrative Expenses	87,843,067	109,956,622	22,113,554	20.1%
(6,126,782)	**(5,691,005)**	**(435,777)**	**(7.7%)**	**Operating Margin**	**1,961,488**	**119,674**	**1,841,813**	**1539.0%**
2,327,893	231,157	2,096,736	907.1%	Non Operating Income (Loss)	13,523,465	2,123,187	11,400,278	536.9%
(3,798,889)	**(5,459,848)**	**1,660,958**	**30.4%**	**Change in Net Assets**	**15,484,952**	**2,242,861**	**13,242,091**	**590.4%**
98.4%	97.5%	(0.9%)		Medical Loss Ratio	96.4%	95.5%	(1.0%)	
4.0%	4.7%	0.7%		Administrative Loss Ratio	3.5%	4.5%	1.0%	
(2.4%)	(2.2%)	(0.1%)		Operating Margin Ratio	0.1%	0.0%	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(4.6)	(4.5)	(0.1)	Medi-Cal	(3.3)	3.3	(6.5)
(1.6)	(1.2)	(0.4)	OCC	4.3	(1.9)	6.2
(0.1)	(0.1)	0.0	OneCare	(0.2)	(1.1)	0.9
0.1	0.0	0.1	PACE	1.0	(0.1)	1.1
(6.1)	**(5.7)**	**(0.4)**	**Operating**	**1.8**	**0.1**	**1.7**
2.3	0.2	2.1	Inv./Rental Inc, MCO tax	13.6	2.1	11.5
2.3	**0.2**	**2.1**	**Non-Operating**	**13.6**	**2.1**	**11.5**
(3.8)	**(5.5)**	**1.7**	**TOTAL**	**15.5**	**2.2**	**13.2**

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Consolidated Revenue & Expense: March 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	531,307	241,014	772,321	14,793	1,335	251	788,700
REVENUES							
Capitation Revenue	$ 119,616,647	$ 105,699,362	$ 225,316,009	$ 29,685,229	$ 1,616,439	$ 1,819,302	$ 258,436,980
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	119,616,647	105,699,362	225,316,009	29,685,229	1,616,439	1,819,302	258,436,980
MEDICAL EXPENSES							
Provider Capitation	34,185,039	49,898,134	84,083,173	11,825,883	440,125	-	96,349,181
Facilities	26,801,600	8,723,099	35,524,699	3,390,132	520,975	329,309	39,765,115
Ancillary	-	-	-	742,594	80,817	-	823,411
Skilled Nursing	-	-	-	-	74,724	-	74,724
Professional Claims	14,822,966	9,508,653	24,331,619	-	-	439,705	24,771,324
Prescription Drugs	18,082,024	18,910,768	36,992,792	4,861,780	440,387	172,379	42,467,337
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	34,221,857	2,450,523	36,672,380	7,788,316	-	-	44,460,697
Medical Management	1,981,919	801,719	2,783,638	991,726	75,014	563,753	4,414,130
Reinsurance & Other	515,820	306,421	822,241	130,000	2,861	106,967	1,062,069
Total Medical Expenses	130,611,224	90,599,318	221,210,542	29,730,430	1,634,903	1,612,113	254,187,988
Medical Loss Ratio	**109.2%**	**85.7%**	**98.2%**	**100.2%**	**101.1%**	**88.6%**	**98.4%**
GROSS MARGIN	**(10,994,577)**	**15,100,044**	**4,105,467**	**(45,201)**	**(18,464)**	**207,189**	**4,248,991**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,690,413	724,688	21,591	70,585	6,507,277
Professional fees			169,955	29,898	13,333	0	213,186
Purchased services			774,394	221,332	20,985	21,110	1,037,820
Printing and Postage			398,215	39,465	2,084	0	439,763
Depreciation and Amortization			462,547	-	-	2,074	464,622
Other expenses			1,308,802	40,069	119	8,865	1,357,855
Indirect cost allocation, Occupancy expense			(132,762)	452,803	28,291	6,918	355,251
Total Administrative Expenses			8,671,563	1,508,255	86,403	109,552	10,375,773
Admin Loss Ratio			**3.8%**	**5.1%**	**5.3%**	**6.0%**	**4.0%**
INCOME (LOSS) FROM OPERATIONS			(4,566,096)	(1,553,457)	(104,867)	97,638	(6,126,782)
INVESTMENT INCOME			-	-	-	-	2,348,961
NET GRANT INCOME			(21,262)	-	-	-	(21,262)
OTHER INCOME			194	-	-	-	194
CHANGE IN NET ASSETS			**$ (4,587,164)**	**$ (1,553,457)**	**$ (104,867)**	**$ 97,638**	**$ (3,798,889)**
BUDGETED CHANGE IN ASSETS			(4,453,559)	(1,167,143)	(109,119)	38,816	(5,459,848)
VARIANCE TO BUDGET - FAV (UNFAV)			(133,606)	(386,314)	4,252	58,822	1,660,958

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Consolidated Revenue & Expense: March 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	4,813,863	2,152,615	6,966,478	136,288	12,302	2,091	7,117,159
REVENUES							
Capitation Revenue	$ 1,245,464,394	$ 967,268,154	$ 2,212,732,547	$ 255,452,873	11,641,094	$ 14,915,561	$ 2,494,742,075
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,245,464,394	967,268,154	2,212,732,547	255,452,873	11,641,094	14,915,561	2,494,742,075
MEDICAL EXPENSES							
Provider Capitation	341,465,901	451,310,896	792,776,797	102,072,163	1,314,137	-	896,163,097
Facilities	230,079,270	153,363,950	383,443,220	28,036,280	4,375,734	2,717,454	418,572,689
Ancillary	-	-	-	5,726,908	496,557	-	6,223,465
Skilled Nursing	-	-	-	-	225,663	-	225,663
Professional Claims	88,402,352	77,157,676	165,560,028	-	-	3,282,454	168,842,481
Prescription Drugs	165,671,502	163,163,842	328,835,344	46,398,913	4,031,273	1,168,420	380,433,950
MLTSS Facility Payments	420,596,630	22,787,195	443,383,825	42,961,015	-	17,988	486,362,828
Medical Management	17,353,445	6,510,203	23,863,648	8,990,755	488,836	4,790,642	38,133,881
Reinsurance & Other	4,929,352	2,707,042	7,636,394	1,383,587	61,146	898,338	9,979,465
Total Medical Expenses	1,268,498,454	877,000,802	2,145,499,256	235,569,621	10,993,347	12,875,296	2,404,937,520
Medical Loss Ratio	**101.8%**	**90.7%**	**97.0%**	**92.2%**	**94.4%**	**86.3%**	**96.4%**
GROSS MARGIN	**(23,034,060)**	**90,267,351**	**67,233,291**	**19,883,252**	**647,747**	**2,040,265**	**89,804,555**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			49,290,768	6,899,295	212,972	695,976	57,099,011
Professional fees			1,305,048	254,622	132,682	38,508	1,730,860
Purchased services			5,910,516	1,537,177	172,115	80,088	7,699,895
Printing and Postage			2,847,183	582,829	62,261	24,969	3,517,241
Depreciation and Amortization			3,708,076	-	-	19,252	3,727,328
Other expenses			10,430,155	393,526	(578)	116,525	10,939,627
Indirect cost allocation, Occupancy expense			(3,105,471)	5,908,119	269,236	57,221	3,129,104
Total Administrative Expenses			70,386,273	15,575,568	848,688	1,032,538	87,843,067
Admin Loss Ratio			**3.2%**	**6.1%**	**7.3%**	**6.9%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			(3,152,982)	4,307,684	(200,941)	1,007,727	1,961,488
INVESTMENT INCOME			-	-	-	-	13,588,656
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(120,287)	-	-	-	(120,287)
OTHER INCOME			993	-	-	-	993
CHANGE IN NET ASSETS			**$ (3,272,276)**	**$ 4,307,684**	**$ (200,941)**	**$ 1,007,727**	**$ 15,484,952**

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Balance Sheet:
As of March 2018

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$872,620,409	Accounts payable	$11,465,633
	Investments	629,313,354	Medical claims liability	1,434,348,789
	Capitation receivable	203,828,866	Accrued payroll liabilities	11,402,098
	Receivables - Other	22,387,573	Deferred revenue	14,565,884
	Prepaid Expenses	5,297,330	Deferred lease obligations	139,894
			Capitation and withholds	84,000,478
	Total Current Assets	**1,733,447,533**	**Total Current Liabilities**	**1,555,922,777**
Capital Assets	Furniture and equipment	35,380,257	Other employment benefits liability	30,142,475
	Building/Leasehold improvements	5,885,793		
	505 City Parkway West	49,743,943	Net Pension Liabilities	15,992,029
		91,009,992	Long Term Liabilities	100,000
	Less: accumulated depreciation	(40,078,904)		
	Capital assets, net	**50,931,088**	**TOTAL LIABILITIES**	**1,602,157,282**
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	24,257,976	Tangible net equity (TNE)	86,464,983
	Long term investments	511,926,899	Funds in excess of TNE	642,478,362
	Total Board-designated Assets	536,184,876		
	Total Other Assets	**536,484,876**	**Net Assets**	**728,943,345**
	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		**2,332,440,636**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,332,440,636**

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Board Designated Reserve and TNE Analysis As of March 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,625,181				
	Tier 1 - Logan Circle	146,594,365				
	Tier 1 - Wells Capital	146,066,476				
Board-designated Reserve		439,286,022	293,288,561	456,040,079	145,997,461	(16,754,057)
TNE Requirement	Tier 2 - Logan Circle	96,898,854	86,464,983	86,464,983	10,433,871	10,433,871
	Consolidated:	536,184,876	379,753,543	542,505,062	156,431,332	(6,320,186)
	Current reserve level	*1.98*	*1.40*	*2.00*		

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HN Enrollment Summary - Medi-Cal

Health Network Name	APRIL 2018	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	149,632	19.4%	22.6%
Monarch Family HealthCare (HMO16)	82,656	10.7%	12.5%
CalOptima Community Network (CN)	75,238	9.7%	11.4%
Arta Western Health Network (SRG66)	67,207	8.7%	10.1%
Family Choice Health Network (PHC21)	46,989	6.1%	7.1%
Alta Med Health Services (SRG69)	46,203	6.0%	7.0%
Kaiser Permanente (HMO04)	45,935	5.9%	6.9%
Prospect Medical Group (HMO17)	34,674	4.5%	5.2%
United Care Medical Network (SRG67)	32,748	4.2%	4.9%
Noble Mid-Orange County (SRG64)	26,561	3.4%	4.0%
Talbert Medical Group (SRG65)	23,874	3.1%	3.6%
AMVI Care Health Network (PHC58)	22,942	3.0%	3.5%
Heritage - Regal Medical Group (HMO15)	5,449	0.7%	0.8%
OC Advantage (PHC35)	2,215	0.3%	0.3%
Total Health Network Capitated Enrollment	**662,322**	**85.8%**	**100.0%**
CalOptima Direct (all others)	109,736	14.2%	
Total Medi-Cal Enrollment	**772,058**	**100.0%**	

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HN Enrollment Summary – OneCare Connect

Health Network Name	APRIL 2018	Percentage
Monarch HealthCare (HMO16DB)	4,800	32.3%
Propect Medical Group (HMO17DB)	2,678	18.0%
Family Choice Medical Group (SRG81DB)	1,821	12.3%
CalOptima Community Network (CN)	1,713	11.5%
Talbert Medical Group (SRG52DB)	1,107	7.4%
Arta Western Health Network(SRG66DB)	535	3.6%
Alta-Med (SRG69DB)	531	3.6%
United Care Medical Group (SRG67DB)	497	3.3%
Noble Mid Orange County (SRG64DB)	455	3.1%
AMVI Care Health Network (PHC58DB)	431	2.9%
Heritage - Regal Medical Group (HMO15)	206	1.4%
OC Advantage (PHC35DB)	90	0.6%
Total OneCare Connect Enrollment	**14,864**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	APRIL 2018	Percentage
Monarch HealthCare (PMG53DE)	671	49.1%
AMVI/Prospect Medical Group (PMG27DE)	306	22.4%
Talbert Medical Group (PMG52DE)	119	8.7%
Family Choice Medical Group (PMG21DE)	90	6.6%
Arta Western Health Network (PMG66DE)	84	6.1%
Alta-Med (PMG69DE)	55	4.0%
United Care Medical Group (PMG67DE)	28	2.0%
Noble Mid Orange County (PMG64DE)	14	1.0%
Total OneCare Enrollment	**1,367**	**100.0%**

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Health Homes Program (HHP)

Provider Advisory Committee
May 10, 2018

Debra Kegel, Manager
Business Integration

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HHP Background: Authorization

- Federal: Authorized under Section 2703 of the Affordable Care Act (ACA)
  - State option to implement
    - May be implemented in phases and in specific geographies
  - 90 percent funding for eight quarters and 50 percent thereafter
  - Must be available to dual eligibles
- State: California's AB 361 (2013) authorizes HHP participation
  - Implementation permitted if no General Funds used
  - Requires Department of Health Care Services evaluation within two years of initial implementation
  - Coordinated Care Initiative counties specifically targeted by DHCS
  - CalOptima anticipated go-live date
    - July 1, 2019, for members with chronic conditions (CC) only
    - January 1, 2020, for those with serious mental illness (SMI), with or without chronic condition

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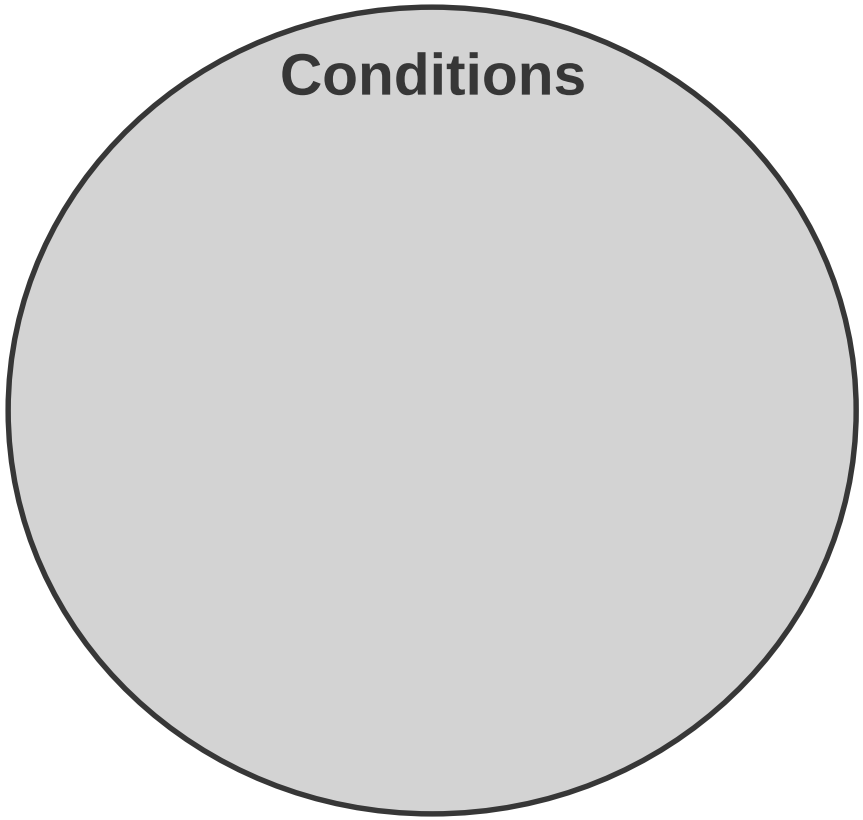
Medi-Cal Members Eligible for HHP

- Conditions/combination of conditions specified by DHCS
  - Chronic physical conditions or
  - Substance use disorder or
  - Serious mental illness
    - Member must have at least two separate services on different dates within 16 months for the identified condition.



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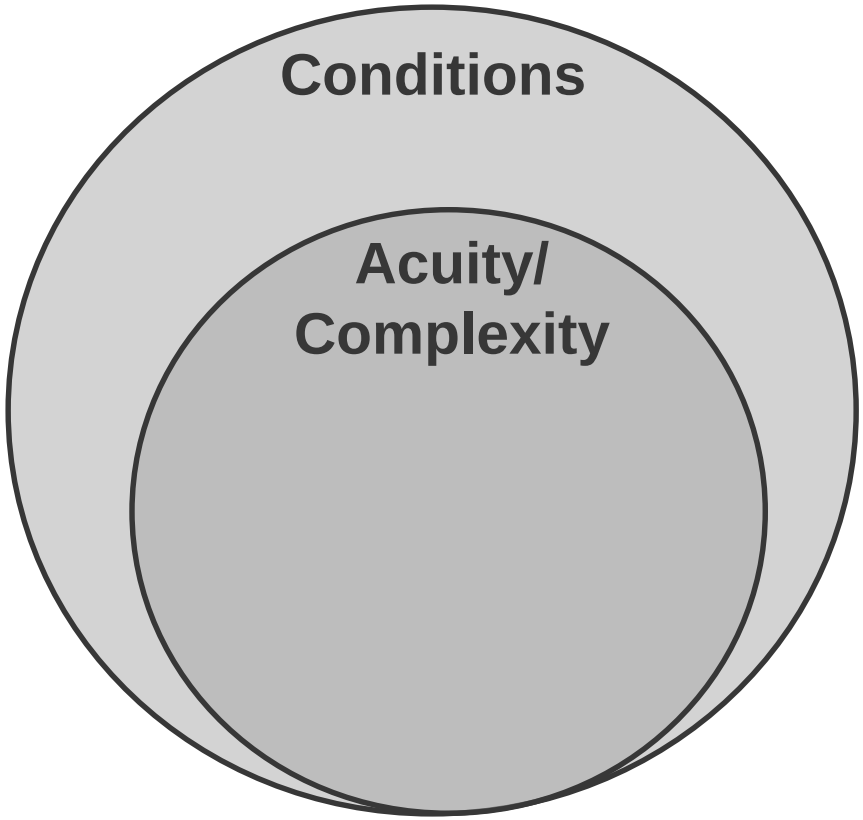
Medi-Cal Members Eligible for HHP (cont.)

- Acuity/complexity (one of the following)
  - Three specified conditions or
  - One inpatient stay or
  - Three emergency department visits in year or
  - Chronic homelessness



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Demographics

- Recent estimates indicate 26,783 Medi-Cal members are HHP eligible and included on the active engagement list.
  - Approximately 18.3 percent are assigned to one of CalOptima's direct networks.
    - Nearly 93 percent are in CalOptima Community Network (CCN) and 7 percent are in CalOptima Direct (COD).
  - Approximately 81.7 percent \are assigned to a delegated health network.
  - Only 23 percent are assigned to Federally Qualified Health Centers or clinics as Primary Care Providers
  - Approximately 7.6 percent may be homeless (based on bad address or other information)

Based on DHCS data received March 15, 2018, and CalOptima member data of April 15, 2018.

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HHP Service Requirements

Enhanced Core Service Categories	New Services
• Provide comprehensive care management. • Conduct health assessments and develop action plans. • Provide comprehensive transitional care. • Offer care coordination and health promotion. • Offer individual and family support. • Make referrals to community and social support services.	• Follow up on referrals to ensure services are offered and accessed. • Accompany highest risk participants to critical appointments (risk tier criterion determined by Managed Care Plan. • Assist homeless members with housing navigation. • Manage transitions from non-hospital or nursing facility settings, such as jail and residential treatment programs. • Assess family/caregiver support. • Develop trauma informed care standards.

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DHCS HHP California Model

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Community-Based Care Management Entity (CB-CME)

- DHCS Expectation
  - "CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services."[1]

- MCP will need to build a CB-CME network to ensure access to HHP services.
- While DHCS expects that most CB-CMEs will be community primary care providers, MCPs have flexibility to identify a more appropriate entity.
- Plans expecting to be CB-CME, must demonstrate that there are insufficient entities in the community willing to and/or capable of providing HHP services.

[1] DHCS Final Guide (3/8/18)

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Delivery Model Considerations

- Must support CalOptima's goals of:
  - Honoring member choice of health network/primary care provider
  - Supporting continuity of care for these most vulnerable members
  - Consistency with DHCS anticipated funding structure
- Leverage our proven delivery model — member receives HHP services consistent with current model of care:
  - HHP members have a choice to keep/select primary care provider.
  - CalOptima would be responsible for enrollment, initial HHP health assessment and health education.
  - CalOptima may use vendors for select services, e.g., accompaniment and housing navigation.
  - Decrease administrative challenges related to existing services provided with higher intensity.

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Questions

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CalOptima's Mission

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

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ER Appropriate Use Collaboration Project

Provider Advisory Committee Meeting

May 10, 2018

Francesco Federico, M.D.

Medical Director

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Strategy Overview

- Information Technology Infrastructure — Data Science
  - Legacy Systems
  - Medical Management Systems
  - Software
  - Data Generation (Goals, A/K, ER/K, Readmit 30 Average Length of Stay, Bed Days per 1,000, Trends Comparisons, Avoidable/saved days)
  - Data Mining — Data Reporting
  - IT Strategy — Analytics (descriptive, diagnostic, predictive, prescriptive)

Strategy Overview (cont.)

- Risk Assessment
  - ER frequenter
  - Facility frequenter (hospital, nursing home)
  - Transition of Care (discharge plan, reconcile, post-discharge follow-up)
  - Polypharmacy
  - Select diagnoses (demographics, conditions)

Strategy Overview (cont.)

- Medical Management
  - Effective processes
  - Best Practices
  - Guidelines (Pathways, Milliman Care Guide, Formulary)

- Care Coordination Continuum Among Parties
  - Providers (PCP, special, hospitalists, SNFists, pharmacy, facilities)
  - Members/Families

Strategy Overview (cont.)

- Care Enhancement
  - Access (PCPs, specialists, vendors, diagnostics)
  - Urgent Care (existing or new)
  - Care Management Processes
    - Levelling
    - Assignment
    - Implementation-focused
  - Resources
    - Palliative and hospice care
    - Home Health and DME
    - Level of Care

Strategy Tactics

- Innovative Programs
  - Post-hospital discharge follow-up within three days
  - Post-hospital status — consider “carte blanche”/walk-in
  - Post-discharge care clinics
  - Post Acute — SNFists, Long Term Care
  - Level of Care appropriate determination (SNF, LTC, subacute)
  - Case Management Focus — highest risk, high risk
  - Care Management Condition Focus (CHF, COPD, DM)
  - Health Management — Disease Management (pregnancy, hypertension)

Past Explanations

- Member
  - PCP access
  - Lack of PCP (with or without influence)
  - ER use culture
  - Lack of education
- Provider
  - PCP access (panel restrict, off hours, culture: sign-out on holidays/weekends, office overflow to ER/urgent care)
- Urgent care locations
  - Adequacy of service
- Member characteristic
  - High disease burden

Past Explanations (cont.)

- Case Management
  - Personnel
    - Adequacy
    - Allocation
  - Transition of Care Focus
  - Post-Acute Care Focus
    - Assignment
    - Medication
  - Provider (PCP, Specialist)
  - Timely Follow-ups with PCP/Specialist — 3-7 days

Data Analytics

- Metrics
  - ER use/1000
  - Readmits (30)
  - Comparative Internal (HN vs CCN, others)

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Past Solutions

- Members
  - Education (access options — clarify wait time, sign-outs)
  - Nurse Call Line (retired)
- Providers (education – access, performance data)
- Urgent Care (location, hours)
- Case Management (identify, levelling, assign)
- Data Science — Early Phase
  - Identification of frequenters
  - Rate of ER use by providers

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Lessons: CMS Hospital Readmission Reductions Programs

- Enlightened Hospitals
  - Transition of Care Vulnerable Period

    (discharge plan, discharge recon, follow-up by most important provider, follow-up within three days before discharge prescriptions delivered)
- Access Expansion (post-discharge clinics, enlighten PCP/specialist
- Follow-up (within three days, post-discharge nurse call
- Post-Acute (SNFists, enlightened nursing homes)
- Care Coordination Across Continuum
  - Focus on outcomes
  - Care coordination across silos of care

Lessons: CMS Hospital Readmission Reductions Programs (cont.)

- Incentives
  - CMS Penalties — up to 3 percent
  - Shift from FFS to CAP
  - ACO (Accountable Care Organizations)
  - Bundled payments

Critical Success Factors

- Access to Care
- Education
  - System access for members
- Communication
  - Post-event transfer of information
- Medical Management
  - Effective processes (evidenced-based guides, outcomes)
- Transition of Care (effectiveness)
- Data Science (metrics, analytics, monitoring, predictive)
- Implementation Effect (teams, performance, accountability)

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Summary

- Medical Management Processes
  - Develop effective processes — comprehensive and accountable
  - Education — effectiveness of dissemination
  - Make vs. Buy (partial vs. whole)
- Information Technology
  - Develop effective internal processes — descriptive and predictive
  - Data generation — inform providers
  - Need for risk/disease burden adjustment
  - Software Aids (make vs. buy)
- Provider Incentives — pros and cons
- Focus on Vulnerable Periods
  - Transitions of Care, Post-Acute, Providers, Communication

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CalOptima Health Network Collaboration Potential

- Data Science
  - Outcomes Focus
  - Best Practices Sharing
  - Innovative Software (make or buy)
  - Metrics Generation/Predictive Analytics
- Care Coordination/Communication
  - Frequenters
  - Relevant Data Transfer (high risk, very high risk)
- Education
  - Providers
  - Members

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CalOptima Health Network Collaboration Potential (cont.)

- Specific Programs
  - Dedicated SNF identified and use
  - ER diversion
  - High-risk level of care determination
  - Innovative incentive arrangements
- Others

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CalOptima's Mission

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

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Medi-Cal

OneCare (HMO SNP)

OneCare Connect

PACE

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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)	2nd Quarter (Oct - Dec 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 4) PAC will receive a presentation at the joint MAC/PAC/OCC MAC meeting on March 8, 2018	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	PAC received an update at the October 2017 meeting on the Data Collection workgroup that was created to help solve data issues related to the Pay for Value and HEDIS programs	**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 3) PAC continued to receive updates at every PAC meeting from CalOptima Executives regarding the transition of the behavioral health services	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 received an update on the Whole Child Care Model at the October 2017 meeting and a Palliative Care update at the at the November 2017 meeting	**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 Q3.**

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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)	2nd Quarter (Oct - Dec 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 Q3.**
		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.**
		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.	1)Explore ideas to broaden access for hard to find providers 2) PAC members slated this as an agenda item at the upcoming MAC/PAC/OCC PAC meeting on March 8, 2018			**Request agenda item in Q4.**

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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)	2nd Quarter (Oct - Dec 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.**	1) Provide timely input on key issues prior to Board decision 2) PAC members slated this as an agenda item at the upcoming MAC/PAC/OCC PAC meeting on March 8, 2018	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.**

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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)	2nd Quarter (Oct - Dec 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 1) PAC Chair shared information with CAPG/APG in the past	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 Q4.**
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						

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