

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

**THURSDAY, FEBRUARY 14, 2019
8:00 A.M.**

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

AGENDA

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

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

I. CALL TO ORDER

Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES

A. Approve Minutes of the December 13, 2018 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

None

VI. CEO AND MANAGEMENT REPORTS

- [A. Chief Executive Officer Update](#)
- B. Chief Operating Officer Update
- C. Chief Medical Officer Update
- [D. Chief Financial Officer Update](#)
- E. Network Operations Update
- [F. Federal and State Legislative Update](#)

VII. INFORMATION ITEMS

- [A. Opioid Crisis Update](#)
- B. Health Homes Program Update
- [C. State Budget Update](#)
- [D. Update on Dental Initiatives](#)
- E. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

MINUTES

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

December 13, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 13, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:04 a.m. Member Lazo-Pearson led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D. (at 8:10 a.m.); Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen (at 8:50 a.m.); Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.

Members Absent: Brian Lee, Ph.D.

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Greg Hamblin, Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Pallavi Patel, Director, Process Excellence; Cheryl Meronk, Director, Strategic Development; Thanh-Tam Nguyen, M.D., Medical Director; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the September 13, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: On motion of Vice Chair Miranti, seconded and carried, the Committee approved the minutes of the September 13, 2018 meeting. (Motion carried 9-0-0; Member Lee absent)

Approve Minutes of the October 11, 2018 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC)

Action: On motion of Member Myers, seconded and carried, the Committee approved the minutes of the October 11, 2018 meeting as presented. (Motion carried 9-0-0; Member Lee absent)

PUBLIC COMMENTS

Pamela Pimentel, MOM's of Orange County, Oral re: Service on PAC

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported that at their December 6, 2018 meeting, the CalOptima Board of Directors approved the allocation of up to \$11.4M from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area funds for enhanced services to be provided to CalOptima Medi-Cal members at the Be Well Wellness Hub. The Wellness Hub must accept all CalOptima members for at least the first five years of operation or later if all the funds have not been exhausted by that date. The remaining \$3.4M in IGT 5 funds will be allocated by the Board for community grants consistent with state-approved funding categories.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, updated the committee on the Whole-Child Model (WCM) postponement. She noted that member notification of the implementation delay is ongoing. To date, seven health networks have met the provider network adequacy standards; four require additional contracts and two have eight to nine deficiencies.

CalOptima is also outreaching to members who have Medicare Part B in order to check their eligibility for Medicare Part A. An update on the Program of All-Inclusive Care for the Elderly (PACE) program was provided, and it was noted that the Department of Health Care Services (DHCS) issued guidance to County Organized Health Systems (COHS) on rules to assist with approving non-COHS PACE providers.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, introduced Thanh-Tam Nguyen, M.D. as the Medical Director for the Whole-Child Model program. Dr. Ramirez also discussed the Pay for Value (P4V) incentives.

Chief Financial Officer Update

Greg Hamblin, Chief Financial Officer, reported that CalOptima anticipates that the Fiscal Year (FY) 2019/200 rates from the state will be released in March or April of 2019. He also noted that CalOptima had recently paid over \$100M back to the DHCS related to the 85%, Medical Loss Ratio (MLR) requirements related to the Medi-Cal expansion population. Mr. Hamblin also

discussed the possibility that the Centers for Medicare & Medicaid Services (CMS) may look at rate setting based on encounters/visits and noted that accurate submittal of patient encounters will be extremely important going forward.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, discussed Medi-Cal enrollment by physicians and noted that at their November 1, 2018 meeting, the Board of Directors authorized CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019. To be eligible, each provider must provide proof of submittal of enrollment documentation to the DHCS prior to January 1, 2019. The Board also authorized Letters of Authorization (LOA) with non-Medi-Cal enrolled specialist providers as required for access to services or continuity of care for members through December 31, 2019.

Federal and State Legislative Update

Arif Shaikh, Director, Government Affairs, reviewed November 6, 2018 election results related to the Orange County legislative delegation.

INFORMATION ITEMS

Whole-Child Model Update

Pallavi Patel, Director, Process Excellence, provided a brief update on the Whole-Child Model postponement and noted that additional information is anticipated during the week of January 7, 2019, and staff will solicit input from the advisory committees when this new information is released. The PAC will hold a special meeting at 8:00 a.m. on Tuesday, January 15, 2019 to review CalOptima's proposed implementation plan.

Intergovernmental Transfer Funds (IGT) 8 and 9 Update

Cheryl Meronk, Director, Strategic Development, presented an update on IGT 8 and 9 funding. Funds for IGT 8, which total approximately \$43M, are expected to be received during the second quarter of 2019. IGT 9, which totals approximately \$42M, has been delayed per DHCS, and a timeline for the funding has not yet been provided. As with all IGTs, IGT 8 and 9 funding must be used for Medi-Cal members. However, rather than being used exclusively for enhanced benefits for existing beneficiaries, these funds must be used for Medi-Cal covered services that are included in CalOptima's DHCS contract. Ms. Meronk reviewed the requirements CalOptima must meet in order to receive IGT funding and noted that the IGT program is subject to change or could face possible elimination from DHCS. Ms. Meronk also noted that proposed expenditure plans for IGT funds will be vetted through the advisory committees and other stakeholder groups.

Children's Hospital of Orange County (CHOC) Pediatric and Adolescent Mental Health Initiative

PAC Traditional/Safety Net Representative Jena Jensen, Chief Government Relations Officer, CHOC, presented an overview of the new CHOC mental health unit for adolescents.

PAC Member Updates

Chair Nishimoto noted that nominations for the Hospital and Nurse Representatives would open in January and asked the PAC members to assist with the recruitment. The selected applicants would fill the remaining term in each seat. The Hospital Representative would serve through June 30, 2020, and the Nurse Representative would serve through June 30, 2021.

ADJOURNMENT

There being no further business before the Committee, Chair Nishimoto wished everyone a happy holiday and adjourned the meeting at 10:05 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Project Manager/Staff to the PAC

Approved: February 14, 2019

MEMORANDUM

DATE: February 7, 2019

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; and Whole-Child Model Family Advisory Committee

Whole-Child Model (WCM) Provider Network Gains Preliminary Approval

Great news! CalOptima received preliminary approval of our WCM provider network. This success is a testament to CalOptima staff and leaders at our delegated networks who responded quickly and effectively to comply with the revised network adequacy standards released by the Department of Health Care Services (DHCS) in November. CalOptima will be submitting contract signature pages by March 1, and DHCS has stated that it will provide final approval of the networks' participation by March 15. To keep stakeholders informed about our ongoing progress toward WCM implementation on July 1, CalOptima held two special meetings with the Provider Advisory Committee and the WCM Family Advisory Committee.

CalOptima Featured in Be Well OC Regional Mental Health and Wellness Campus Debut

On January 29, Orange County learned about the public-private partnership focused on changing our community's mental health system of care. The County of Orange approved a \$16.6 million investment in the Be Well OC Regional Mental Health and Wellness Campus. This joins CalOptima's commitment of \$11.4 million for services in the new facility as well as \$12 million from Kaiser and St. Joseph Hoag Health. The campus aspires to create a new approach to mental health care that brings together a range of services from prevention and early intervention to acute care and recovery. Construction of the 60,000-square-foot facility begins in the spring. CalOptima participated in the initial press conference announcing the campus, and we anticipate further coverage as news of this first-of-its-kind facility travels.

Supervisor Doug Chaffee Appointed as Alternate CalOptima Board Member

As the new supervisor for Orange County's Fourth District, Doug Chaffee was appointed by Chairwoman Lisa Bartlett to serve as the alternate on CalOptima's Board of Directors, effective January 29. Bartlett also reappointed Supervisors Andrew Do and Michelle Steel as CalOptima Board members. Prior to Supervisor Chaffee's appointment, I met with him to share an overview of CalOptima, including our history, membership and programs. Supervisor Chaffee expressed his appreciation for CalOptima's service to the 180,000 members in his district.

California Governor Sets Out Ambitious Health Care Platform

Gov. Gavin Newsom began his term on January 7, and right away, he made it clear that health care would be a central focus of his administration's agenda. He announced a plan to expand Medi-Cal to cover undocumented young adults, proposed a statewide individual health insurance

mandate and issued an executive order to consolidate pharmacy purchasing to lower drug costs. As you know, he campaigned on a universal health care platform, so his proposals signal he intends to work diligently toward changes that address gaps in coverage, access and cost. Given the scope and significance of the governor's early effort, CalOptima is planning on extensive advocacy work alongside our associations to ensure the interests of our members are considered.

Proposed State Budget Signals Changes in Health Care Landscape

On January 10, Gov. Newsom released his FY 2019–20 state budget proposal, which provides additional detail regarding his ambitious health policy agenda. One of the most impactful elements of this agenda is the carve-out of prescription drugs from Medi-Cal managed care and the return of this benefit to a fee-for-service model no sooner than January 1, 2021, as part of an overall plan to boost the state's negotiating power with pharmaceutical companies. Despite the information in the budget proposal, many aspects of this transition are yet to be defined, and we plan to engage our associations to influence this potentially major change. Separately, regarding the proposed expansion of Medi-Cal to approximately 138,000 undocumented individuals ages 19 through 25, the budget includes the expected cost of \$260 million in FY 2019–20. Further, the budget proposes to maintain existing Prop. 56 supplemental payments to providers and create new programs funded by these revenues, which total \$3.2 billion for FY 2019–20. One new Prop. 56 program would establish incentives for providers to increase or improve services in high-impact areas, such as behavioral health, prenatal/postpartum care or chronic disease management. Both the expansion of Medi-Cal and the Prop. 56 changes would require legislation to implement. Further, these changes are predicated on the new administration's expectation that the state's economy will experience moderate growth in the next fiscal year. The governor's May Revise could include adjustments based on an updated economic outlook or potential federal policy changes.

Texas Affordable Care Act (ACA) Ruling Raises Questions About Stability of the Law

As was widely reported, a federal judge in Texas issued a ruling in December that could impact the future of the ACA. Specifically, he found that the ACA is unconstitutional based on the removal of the individual mandate tax penalty. The ACA drove the expansion of Medi-Cal and thus CalOptima's growth in membership since 2014. That said, the ruling is far from final, and government officials and legal experts expect an appeal will likely reach the U.S. Supreme Court. Until appeals are resolved, the Texas judge granted a stay, so the law is unchanged for our Medi-Cal expansion members. CalOptima will advocate through our state and national trade associations to ensure the stability of the ACA.

Homeless Health Is the Central Topic of Meetings With County Leaders

In January, CalOptima participated in key meetings addressing homeless health:

- **Judge David O. Carter:** Supervisor Andrew Do, Orange County Health Care Agency Director Richard Sanchez and I met with Judge Carter to discuss CalOptima's activities in homeless health given Orange County's ongoing homeless crisis.
- **County Agencies:** CalOptima and county leaders, including representatives from the Health Care Agency, Social Services Agency and Office of Care Coordination, met twice in January to tackle issues related to improving services for our community's homeless population. The first meeting clarified the resources available from the county and CalOptima. The second meeting focused on how to deliver physical health to homeless individuals where they are.

As a result of the meetings with the county and the judge, staff are developing proposals in collaboration with stakeholders to address the gaps in the system that separate members who are homeless from the health care they need. While the current delivery system does not work for them, there is no single alternative solution. Thus, CalOptima is exploring a flexible, multipronged approach. Our proposals center on enhanced same-day transportation, increased use of mobile clinics at shelters and clinical field teams that deliver care on the street when necessary. An Information Item at your Board meeting this month will provide additional details.

CalOptima Requests Flexibility in Start Date for Health Homes Program (HHP)

HHP is designed to serve Medi-Cal members with multiple chronic conditions who may benefit from enhanced care management and coordination. At this time, CalOptima is slated to participate in the HHP starting July 1, 2019, which is the same go-live date as the WCM transition. Our regulatory team recently asked DHCS officials if there is any flexibility around that date due to the overlap and associated demands on staff and health networks. Additionally, DHCS provided guidance requiring modifications to our proposed approach to HHP using the delegated model. CalOptima expects feedback on the issue of timing and our HHP model during an upcoming conference call with the state.



CalOptima
Better. Together.

Financial Summary

December 2018

Greg Hamblin
Chief Financial Officer

FY 2018-19: Consolidated Enrollment

- December 2018 MTD:
 - Overall enrollment was 766,194 member months
 - Actual lower than budget 17,702 or 2.3%
 - Medi-Cal: unfavorable variance of 17,248 members
 - Temporary Assistance for Needy Families (TANF) unfavorable variance of 10,394 members
 - Medi-Cal Expansion (MCE) unfavorable variance of 6,289 members
 - Seniors and Persons with Disabilities (SPD) unfavorable variance of 501 members
 - Long-Term Care (LTC) unfavorable variance of 64 members
 - OneCare Connect: unfavorable variance of 560 members
 - 3,022 decrease from November
 - Medi-Cal: decrease of 2,729 from November
 - OneCare Connect: decrease of 309 from November
 - OneCare: increase of 12 from November
 - PACE: increase of 4 from November

FY 2018-19: Consolidated Enrollment (cont.)

- December 2018 YTD:

- Overall enrollment was 4,637,071 member months
 - Actual lower than budget 70,090 members or 1.5%
 - Medi-Cal: unfavorable variance of 69,027 members or 1.5%
 - TANF unfavorable variance of 38,584 members
 - MCE unfavorable variance of 27,884 members
 - SPD unfavorable variance of 2,147 members
 - LTC unfavorable variance of 412 members
 - OneCare Connect: unfavorable variance of 1,536 members or 1.7%
 - OneCare: favorable variance of 467 members or 5.9%
 - PACE: favorable variance of 6 members or 0.3%

FY 2018-19: Consolidated Revenues

- December 2018 MTD:
 - Actual lower than budget \$14.8 million or 5.3%
 - Medi-Cal: unfavorable to budget \$14.2 million or 5.7%
 - Unfavorable volume variance of \$5.6 million
 - Unfavorable price variance of \$8.6 million
 - OneCare Connect: unfavorable to budget \$0.6 million or 2.4%
 - Unfavorable volume variance of \$0.9 million
 - Favorable price variance of \$0.3 million
 - OneCare: favorable to budget \$158.6 thousand or 9.9%
 - Favorable volume variance of \$133.7 thousand
 - Favorable price variance of \$24.9 thousand
 - PACE: Unfavorable to budget \$202.4 thousand or 9.2%
 - Unfavorable volume variance of \$36.3 thousand
 - Unfavorable price variance of \$166.2 thousand

FY 2018-19: Consolidated Revenues (cont.)

- December 2018 YTD:

- Actual lower than budget \$24.0 million or 1.4%

- Medi-Cal: unfavorable to budget \$25.1 million or 1.7%

- Unfavorable volume variance of \$22.3 million

- Unfavorable price variance of \$2.8 million due to:

- \$8.0 million of FY18 non-LTC revenue from non-LTC aid codes

- \$2.7 million of FY19 Behavioral Health Treatment (BHT) revenue

- Offset by favorable variance due to:

- \$4.5 million of prior year non-LTC revenue from non-LTC aid codes

- \$2.2 million of FY19 Hepatitis C revenue

- \$1.1 million of prior year BHT revenue

FY 2018-19: Consolidated Revenues (cont.)

- December 2018 YTD:

- OneCare Connect: favorable to budget \$1.5 million or 1.0%
 - Unfavorable volume variance of \$2.6 million
 - Favorable price variance of \$4.1 million related to:
 - \$1.7 million Calendar Year (CY) 2016 Hierarchical Condition Category (HCC) risk adjustment
 - \$1.7 million for prior year Quality Incentive (QI) withhold distributed by the Centers for Medicare & Medicaid Services (CMS)
- OneCare: unfavorable to budget \$0.4 million or 4.4%
 - Favorable volume variance of \$0.6 million
 - Unfavorable price variance of \$1.0 million due to:
 - \$0.9 million CY 2015 risk adjustment
 - \$0.2 million CY 2016 HCC risk adjustment
- PACE: favorable to budget \$50.7 thousand or 0.4%
 - Favorable volume variance of \$43.5 thousand
 - Favorable price variance of \$7.2 thousand

FY 2018-19: Consolidated Medical Expenses

- December 2018 MTD:

- Actual lower than budget \$17.9 million or 6.7%
 - Medi-Cal: favorable variance of \$16.6 million
 - Favorable volume variance of \$5.4 million
 - Favorable price variance of \$11.2 million
 - Professional Claim expenses favorable variance of \$9.4 million due to:
 - Child Health and Disability Prevention Program (CHDP) expenses of \$2.0 million
 - BHT expenses of \$3.7 million
 - Proposition 56 expenses of \$2.6 million
 - Prescription Drug expenses favorable variance of \$5.1 million
 - Provider Capitation expenses unfavorable variance of \$4.1 million due to Proposition 56 and CHDP expenses that were budgeted in Professional Claims
 - Managed Long Term Services and Supports (MLTSS) expenses favorable variance of \$3.4 million

FY 2018-19: Consolidated Medical Expenses (cont.)

- December 2018 MTD:

- OneCare Connect: favorable variance of \$946.9 thousand or 3.9%

- Favorable volume variance of \$907.7 thousand

- Favorable price variance of \$39.2 thousand

- OneCare: favorable variance of \$46.2 thousand or 3.0%

- PACE: favorable variance of \$329.7 thousand or 16.3%

FY 2018-19: Consolidated Medical Expenses (cont.)

- December 2018 YTD:

- Actual lower than budget \$40.3 million or 2.5%
 - Medi-Cal: favorable variance of \$39.2 million
 - Favorable volume variance of \$21.2 million
 - Favorable price variance of \$18.0 million
 - Professional Claim expenses favorable variance of \$37.9 million
 - Provider Capitation expenses unfavorable variance of \$22.7 million
 - Facilities expenses unfavorable variance of \$17.4 million
 - Prescription Drug expenses favorable variance of \$12.7 million
 - MLTSS expenses favorable variance of \$7.4 million
 - OneCare Connect: unfavorable variance of \$0.1 million
 - Favorable volume variance of \$2.5 million
 - Unfavorable price variance of \$2.6 million

- Medical Loss Ratio (MLR):

- December 2018 MTD: Actual: 94.3% Budget: 95.8%
- December 2018 YTD: Actual: 94.2% Budget: 95.3%

FY 2018-19: Consolidated Administrative Expenses

- December 2018 MTD:
 - Actual lower than budget \$2.6 million or 20.7%
 - Salaries, wages and benefits: favorable variance of \$1.1 million
 - Other categories: favorable variance of \$1.5 million
- December 2018 YTD:
 - Actual lower than budget \$14.7 million or 19.5%
 - Salaries, wages & benefits: favorable variance of \$7.2 million
 - Purchased Services: favorable variance of \$2.4 million
 - Other categories: favorable variance of \$5.2 million
- Administrative Loss Ratio (ALR):
 - December 2018 MTD: Actual: 3.7% Budget: 4.5%
 - December 2018 YTD: Actual: 3.7% Budget: 4.6%

FY 2018-19: Change in Net Assets

- December 2018 MTD:

- \$10.2 million surplus
- \$10.4 million favorable to budget
 - Lower than budgeted revenue of \$14.8 million
 - Lower than budgeted medical expenses of \$17.9 million
 - Lower than budgeted administrative expenses of \$2.6 million
 - Higher than budgeted investment and other income of \$4.7 million

- December 2018 YTD:

- \$51.0 million surplus
- \$45.3 million favorable to budget
 - Lower than budgeted revenue of \$24.0 million
 - Lower than budgeted medical expenses of \$40.3 million
 - Lower than budgeted administrative expenses of \$14.7 million
 - Higher than budgeted investment and other income of \$14.3 million

Enrollment Summary:

December 2018

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
64,469	64,891	(422)	(0.7%)	Aged	383,953	385,986	(2,033)	(0.5%)
586	620	(34)	(5.5%)	BCCTP	3,647	3,720	(73)	(2.0%)
47,104	47,149	(45)	(0.1%)	Disabled	282,718	282,759	(41)	(0.0%)
305,557	314,115	(8,558)	(2.7%)	TANF Child	1,862,044	1,892,471	(30,427)	(1.6%)
92,254	94,090	(1,836)	(2.0%)	TANF Adult	561,578	569,735	(8,157)	(1.4%)
3,440	3,504	(64)	(1.8%)	LTC	20,447	20,859	(412)	(2.0%)
236,749	243,038	(6,289)	(2.6%)	MCE	1,424,752	1,452,636	(27,884)	(1.9%)
750,159	767,407	(17,248)	(2.2%)	Medi-Cal	4,539,139	4,608,166	(69,027)	(1.5%)
14,301	14,861	(560)	(3.8%)	OneCare Connect	87,793	89,329	(1,536)	(1.7%)
299	304	(5)	(1.6%)	PACE	1,728	1,722	6	0.3%
1,435	1,324	111	8.4%	OneCare	8,411	7,944	467	5.9%
766,194	783,896	(17,702)	(2.3%)	CalOptima Total	4,637,071	4,707,161	(70,090)	(1.5%)

Financial Highlights:

December 2018

Month-to-Date

Actual	Budget	\$ Budget	% Budget
766,194	783,896	(17,702)	(2.3%)
262,985,245	277,802,172	(14,816,927)	(5.3%)
248,114,941	266,000,586	17,885,645	6.7%
9,860,640	12,432,137	2,571,497	20.7%
5,009,664	(630,550)	5,640,215	894.5%
5,155,302	416,667	4,738,635	1137.3%
10,164,966	(213,884)	10,378,850	4852.6%
94.3%	95.8%	1.4%	
3.7%	4.5%	0.7%	
<u>1.9%</u>	<u>(0.2%)</u>	2.1%	
100.0%	100.0%		

Year-to-Date

	Actual	Budget	S Budget	% Budget
Member Months	4,637,071	4,707,161	(70,090)	(1.5%)
Revenues	1,636,766,437	1,660,779,599	(24,013,163)	(1.4%)
Medical Expenses	1,541,700,995	1,582,029,099	40,328,103	2.5%
Administrative Expenses	60,827,232	75,571,445	14,744,213	19.5%
Operating Margin	34,238,210	3,179,056	31,059,154	977.0%
Non Operating Income (Loss)	16,776,520	2,500,000	14,276,520	571.1%
Change in Net Assets	51,014,729	5,679,056	45,335,673	798.3%
Medical Loss Ratio	94.2%	95.3%	1.1%	
Administrative Loss Ratio	3.7%	4.6%	0.8%	
Operating Margin Ratio	2.1%	0.2%	1.9%	
Total Operating	100.0%	100.0%		

Consolidated Performance Actual vs. Budget: December 2018 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
5.4	0.7	4.6	Medi-Cal	37.0	9.9	27.1
(0.6)	(1.3)	0.6	OCC	(3.7)	(6.4)	2.6
0.1	(0.1)	0.2	OneCare	(0.4)	(0.4)	0.0
<u>0.2</u>	<u>0.0</u>	<u>0.2</u>	<u>PACE</u>	<u>1.4</u>	<u>0.1</u>	<u>1.3</u>
5.0	(0.6)	5.7	Operating	34.2	3.2	31.1
<u>5.2</u>	<u>0.4</u>	<u>4.7</u>	<u>Inv./Rental Inc, MCO tax</u>	<u>16.8</u>	<u>2.5</u>	<u>14.3</u>
5.2	0.4	4.7	Non-Operating	16.8	2.5	14.3
10.2	(0.2)	10.4	TOTAL	51.0	5.7	45.3

Consolidated Revenue & Expense:

December 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	513,410	236,749	750,159	14,301	1,435	299	766,194
REVENUES							
Capitation Revenue	\$ 125,346,798	\$ 109,800,211	\$ 235,147,010	\$ 24,081,787	\$ 1,753,661	\$ 2,002,788	\$ 262,985,245
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	125,346,798	109,800,211	235,147,010	24,081,787	1,753,661	2,002,788	262,985,245
MEDICAL EXPENSES							
Provider Capitation	35,052,513	50,718,354	85,770,867	11,066,222	761,289	-	97,598,377
Facilities	21,868,443	23,023,541	44,891,985	3,314,687	109,126	317,490	48,633,288
Ancillary	-	-	-	691,789	37,556	-	729,346
Professional Claims	13,672,077	5,454,294	19,126,371	-	-	373,313	19,499,684
Prescription Drugs	15,537,299	17,261,037	32,798,336	5,171,614	499,317	177,111	38,646,379
MLTSS	30,483,287	2,439,216	32,922,503	1,385,406	8,914	30,413	34,347,236
Medical Management	2,445,657	1,294,581	3,740,238	941,038	88,460	655,796	5,425,533
Quality Incentives	764,967	411,445	1,176,412	284,120	-	2,990	1,463,522
Reinsurance & Other	862,919	482,801	1,345,720	286,262	2,836	136,757	1,771,575
Total Medical Expenses	120,687,162	101,085,268	221,772,430	23,141,140	1,507,499	1,693,871	248,114,941
Medical Loss Ratio	96.3%	92.1%	94.3%	96.1%	86.0%	84.6%	94.3%
GROSS MARGIN	4,659,636	8,714,943	13,374,579	940,647	246,161	308,917	14,870,304
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,928,283	666,664	29,675	90,743	6,715,365
Professional fees			(53,928)	25,374	14,667	123	(13,764)
Purchased services			658,204	187,202	7,396	5,713	858,515
Printing & Postage			120,886	134,161	7,178	27	262,252
Depreciation & Amortization			485,425	-	-	2,128	487,553
Other expenses			1,185,469	38,835	(1,332)	786	1,223,758
Indirect cost allocation & Occupancy			(289,184)	532,164	73,716	10,263	326,960
Total Administrative Expenses			8,035,154	1,584,401	131,300	109,784	9,860,640
Admin Loss Ratio			3.4%	6.6%	7.5%	5.5%	3.7%
INCOME (LOSS) FROM OPERATIONS			5,339,425	(643,755)	114,861	199,133	5,009,664
INVESTMENT INCOME							5,133,996
TOTAL GRANT INCOME			21,306				21,306
CHANGE IN NET ASSETS			\$ 5,360,731	\$ (643,755)	\$ 114,861	\$ 199,133	\$ 10,164,966
BUDGETED CHANGE IN NET ASSETS			733,429	(1,281,406)	(89,220)	6,647	(213,884)
VARIANCE TO BUDGET - FAV (UNFAV)			\$ 4,627,302	\$ 637,651	\$ 204,082	\$ 192,486	\$ 10,378,850

Consolidated Revenue & Expense:

December 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,114,387	1,424,752	4,539,139	87,793	8,411	1,728	4,637,071
REVENUES							
Capitation Revenue	\$ 801,624,477	\$ 662,985,670	\$ 1,464,610,147	\$ 150,497,405	\$ 9,128,212	\$ 12,530,672	#####
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	801,624,477	662,985,670	1,464,610,147	150,497,405	9,128,212	12,530,672	1,636,766,437
MEDICAL EXPENSES							
Provider Capitation	213,577,615	302,277,528	515,855,143	69,493,852	2,469,579	-	587,818,574
Facilities	136,057,853	139,539,067	275,596,920	19,946,595	2,660,610	2,184,598	300,388,723
Ancillary	-	-	-	3,877,255	197,361	-	4,074,616
Professional Claims	93,509,922	36,670,574	130,180,496	-	-	2,522,621	132,703,116
Prescription Drugs	101,455,674	115,395,611	216,851,285	32,310,012	2,744,846	961,933	252,868,075
MLTSS	191,278,718	16,717,999	207,996,717	8,771,240	438,116	28,480	217,234,552
Medical Management	12,562,488	6,172,978	18,735,466	6,592,850	354,312	3,711,921	29,394,549
Quality Incentives	4,625,270	2,454,726	7,079,996	1,832,600	-	17,280	8,929,876
Reinsurance & Other	3,680,715	2,186,226	5,866,941	1,405,916	37,095	978,961	8,288,914
Total Medical Expenses	756,748,255	621,414,709	1,378,162,964	144,230,319	8,901,919	10,405,794	1,541,700,995
Medical Loss Ratio	94.4%	93.7%	94.1%	95.8%	97.5%	83.0%	94.2%
GROSS MARGIN	44,876,222	41,570,961	86,447,184	6,267,086	226,293	2,124,878	95,065,441
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			35,517,461	4,454,911	191,569	574,076	40,738,017
Professional fees			906,072	180,298	88,001	6,244	1,180,615
Purchased services			3,859,499	1,066,507	85,011	53,262	5,064,278
Printing & Postage			1,816,806	419,908	42,706	21,108	2,300,529
Depreciation & Amortization			2,420,717	-	-	12,493	2,433,210
Other expenses			6,733,391	261,678	263	15,358	7,010,691
Indirect cost allocation & Occupancy			(1,767,843)	3,620,177	219,577	27,980	2,099,891
Total Administrative Expenses			49,486,103	10,003,479	627,128	710,523	60,827,232
Admin Loss Ratio			3.4%	6.6%	6.9%	5.7%	3.7%
INCOME (LOSS) FROM OPERATIONS			36,961,081	(3,736,392)	(400,835)	1,414,355	34,238,210
INVESTMENT INCOME							16,772,561
TOTAL GRANT INCOME			3,262				3,262
OTHER INCOME			697				697
CHANGE IN NET ASSETS			\$ 36,965,040	\$ (3,736,392)	\$ (400,835)	\$ 1,414,355	\$ 51,014,729
BUDGETED CHANGE IN NET ASSETS			9,888,151	(6,374,061)	(421,351)	86,317	5,679,056
VARIANCE TO BUDGET - FAV (UNFAV)			\$ 27,076,889	\$ 2,637,669	\$ 20,516	\$ 1,328,038	\$ 45,335,673

Balance Sheet:

As of December 2018

ASSETS

Current Assets	
Operating Cash	\$457,794,347
Investments	420,689,952
Capitation receivable	317,548,692
Receivables - Other	19,077,811
Prepaid expenses	5,453,518
Total Current Assets	1,220,564,321
Capital Assets	
Furniture & Equipment	35,575,437
Building/Leasehold Improvements	7,666,542
505 City Parkway West	50,061,228
	93,303,207
Less: accumulated depreciation	(44,598,766)
Capital assets, net	48,704,441
Other Assets	
Restricted Deposit & Other	300,000
Board-designated assets	
Cash and Cash Equivalents	24,279,851
Long-term Investments	521,963,338
Total Board-designated Assets	546,243,189
Total Other Assets	546,543,189
TOTAL ASSETS	1,815,811,951
Deferred Outflows	
Pension Contributions	953,907
Difference in Experience	1,365,903
Excess Earnings	1,017,387
Changes in Assumptions	7,795,853
TOTAL ASSETS & DEFERRED OUTFLOWS	1,826,945,001

LIABILITIES & FUND BALANCES

Current Liabilities	
Accounts Payable	\$39,327,789
Medical Claims liability	708,778,778
Accrued Payroll Liabilities	10,008,152
Deferred Revenue	85,678,907
Deferred Lease Obligations	82,664
Capitation and Withholds	116,807,067
Total Current Liabilities	960,683,359
Other (than pensions) post employment benefits liability	25,320,737
Net Pension Liabilities	24,865,229
Bldg 505 Development Rights	100,000
TOTAL LIABILITIES	1,010,969,324
Deferred Inflows	
Change in Assumptions	3,329,380
TNE	81,596,204
Funds in Excess of TNE	731,050,093
Net Assets	812,646,296
TOTAL LIABILITIES & FUND BALANCES	1,826,945,001

Board Designated Reserve and TNE Analysis

As of December 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	149,467,614				
	Tier 1 - Logan Circle	149,216,560				
	Tier 1 - Wells Capital	148,838,193				
Board-designated Reserve						
		447,522,367	310,055,167	477,905,754	137,467,200	(30,383,387)
TNE Requirement	Tier 2 - Logan Circle	98,720,822	81,596,204	81,596,204	17,124,618	17,124,618
	Consolidated:	546,243,189	391,651,371	559,501,958	154,591,818	(13,258,769)
	<i>Current reserve level</i>	<i>1.95</i>	<i>1.40</i>	<i>2.00</i>		





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Opioid Epidemic Update

Provider Advisory Committee
February 14, 2019

David Ramirez, M.D.
Chief Medical Officer

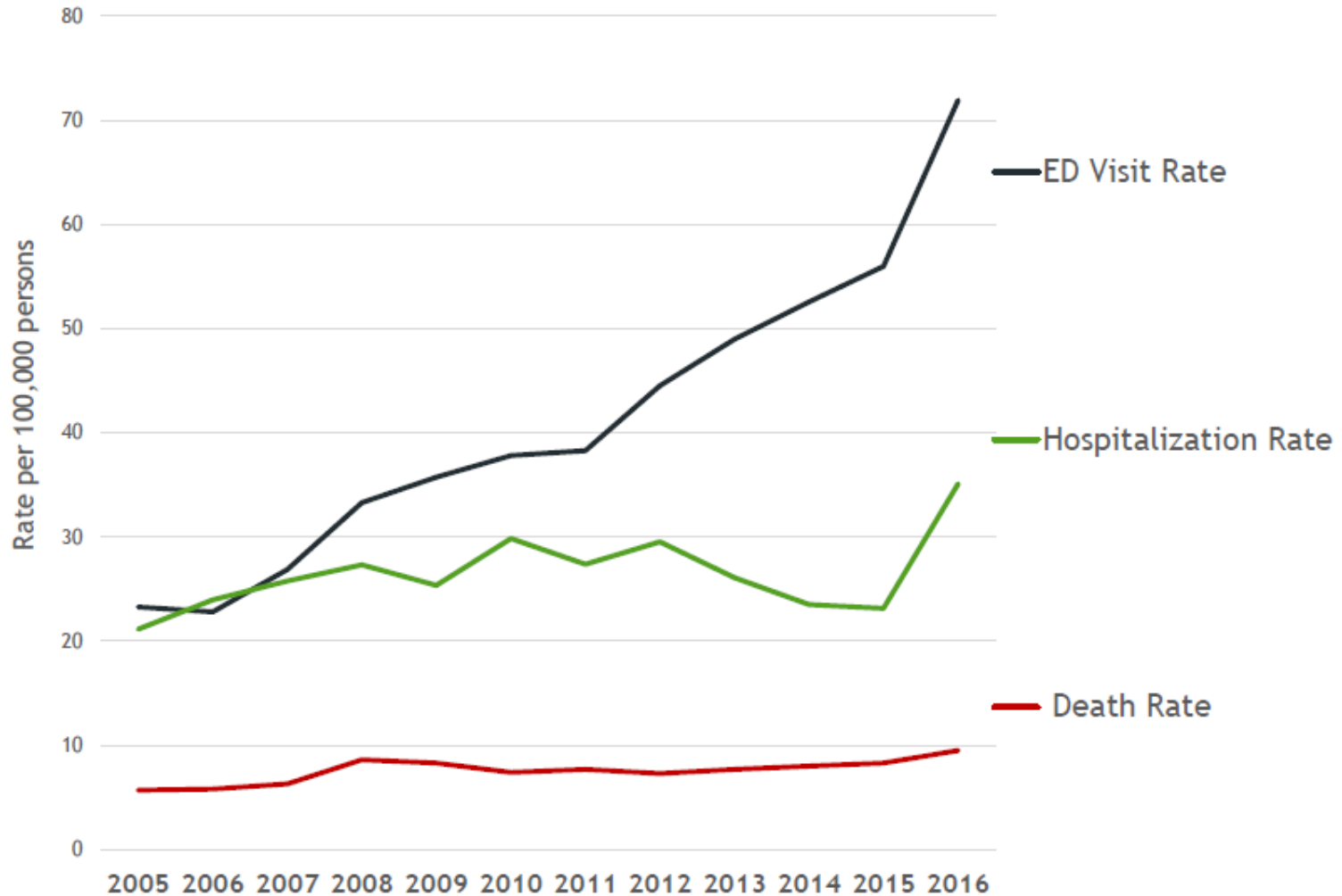
Opioid Epidemic

- Drug overdose is the leading cause of unintentional death in the United States, causing more deaths than motor vehicle accidents.
- Of the more than 70,200 drug overdose deaths in 2017, 68% involved an opioid.
- The most common drugs involved in prescription opioid overdose deaths include:
 - Methadone
 - Oxycodone (such as OxyContin®)
 - Hydrocodone (such as Vicodin®)
- Prescription opioid overdose deaths also often involve benzodiazepines such as:
 - Alprazolam (Xanax®)
 - Diazepam (Valium®)
 - Lorazepam (Ativan®)

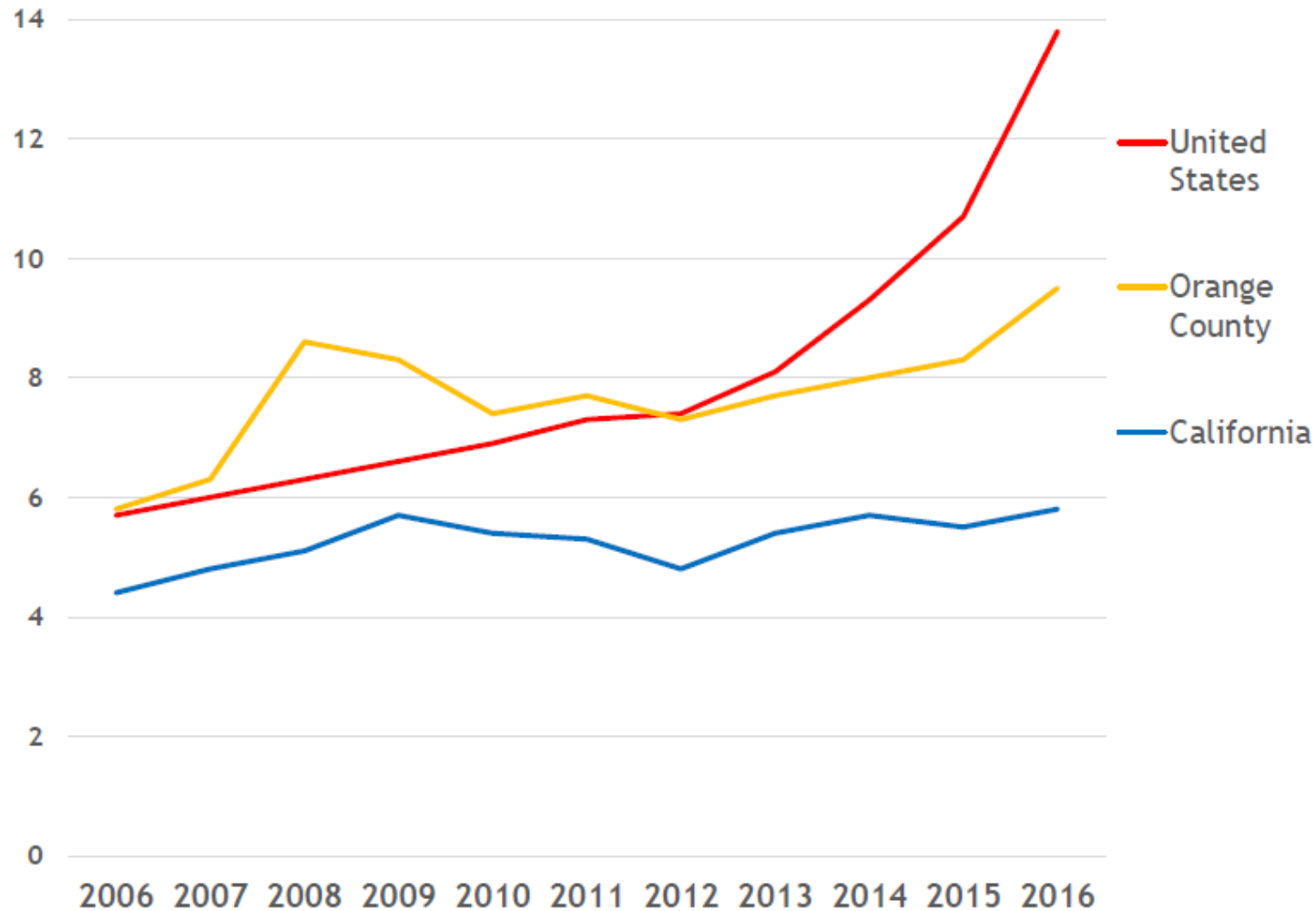
Impact On Medicaid

- Inappropriate prescribing practices and opioid prescribing rates are substantially higher among Medicaid patients than among privately insured patients
- In one study based on 2010 data, 40% of Medicaid enrollees with prescriptions for pain relievers had at least one indicator of potentially inappropriate use or prescribing:
 - Overlapping prescriptions for pain relievers
 - Overlapping pain reliever and benzodiazepine prescriptions
 - Long-acting or extended release prescription pain relievers for acute pain, and
 - High daily opioid doses

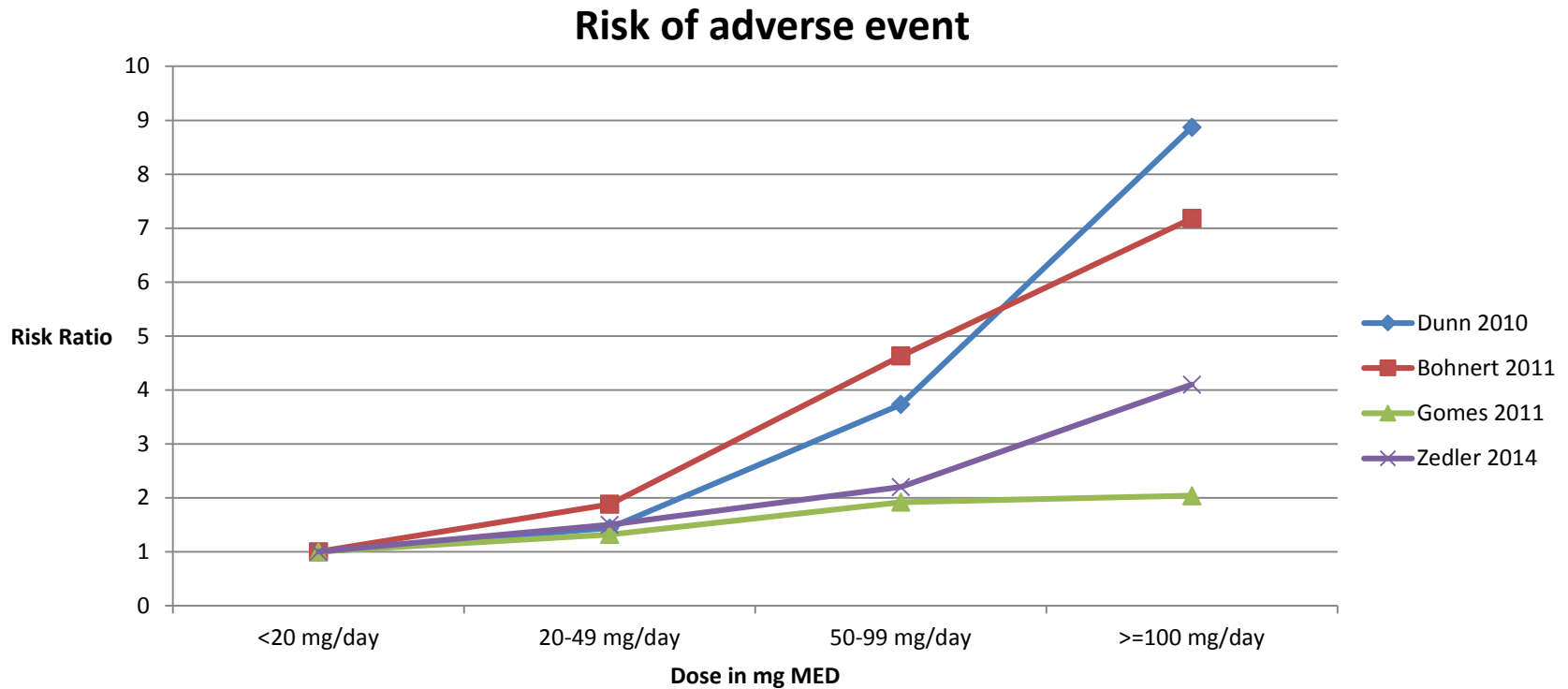
Orange County Opioid Statistics



Opioid Overdose Death Rates

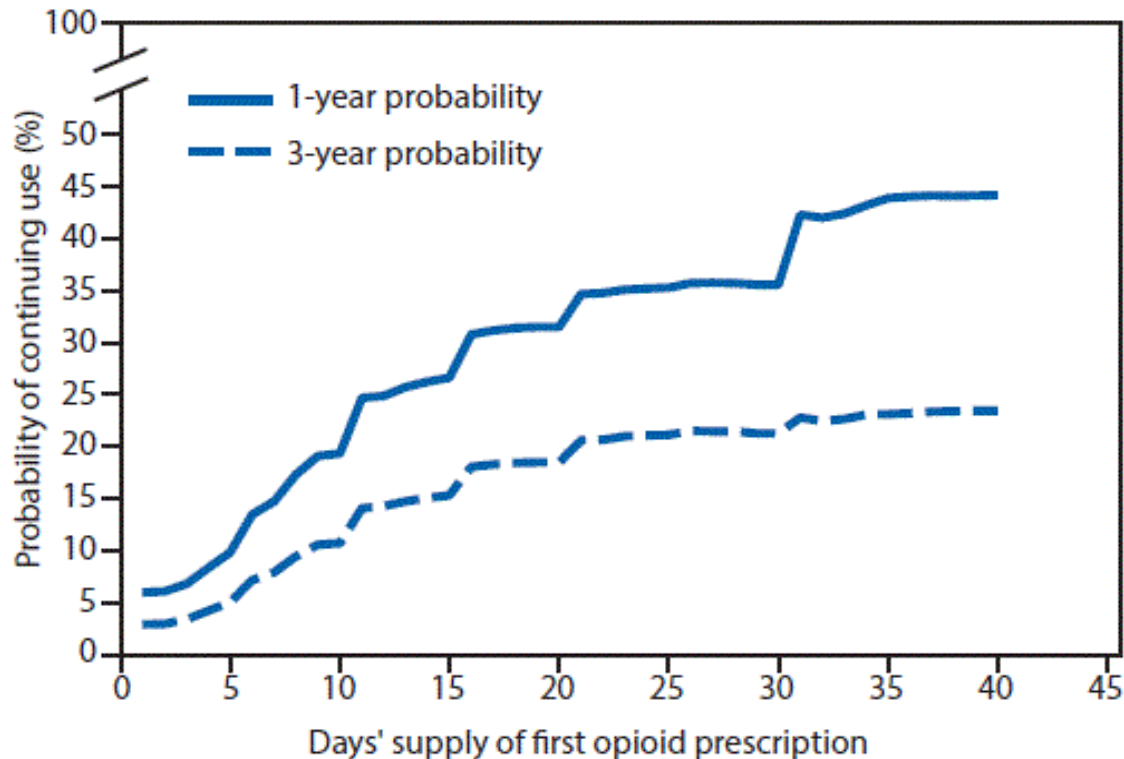


Opioid Dose-Related Risk

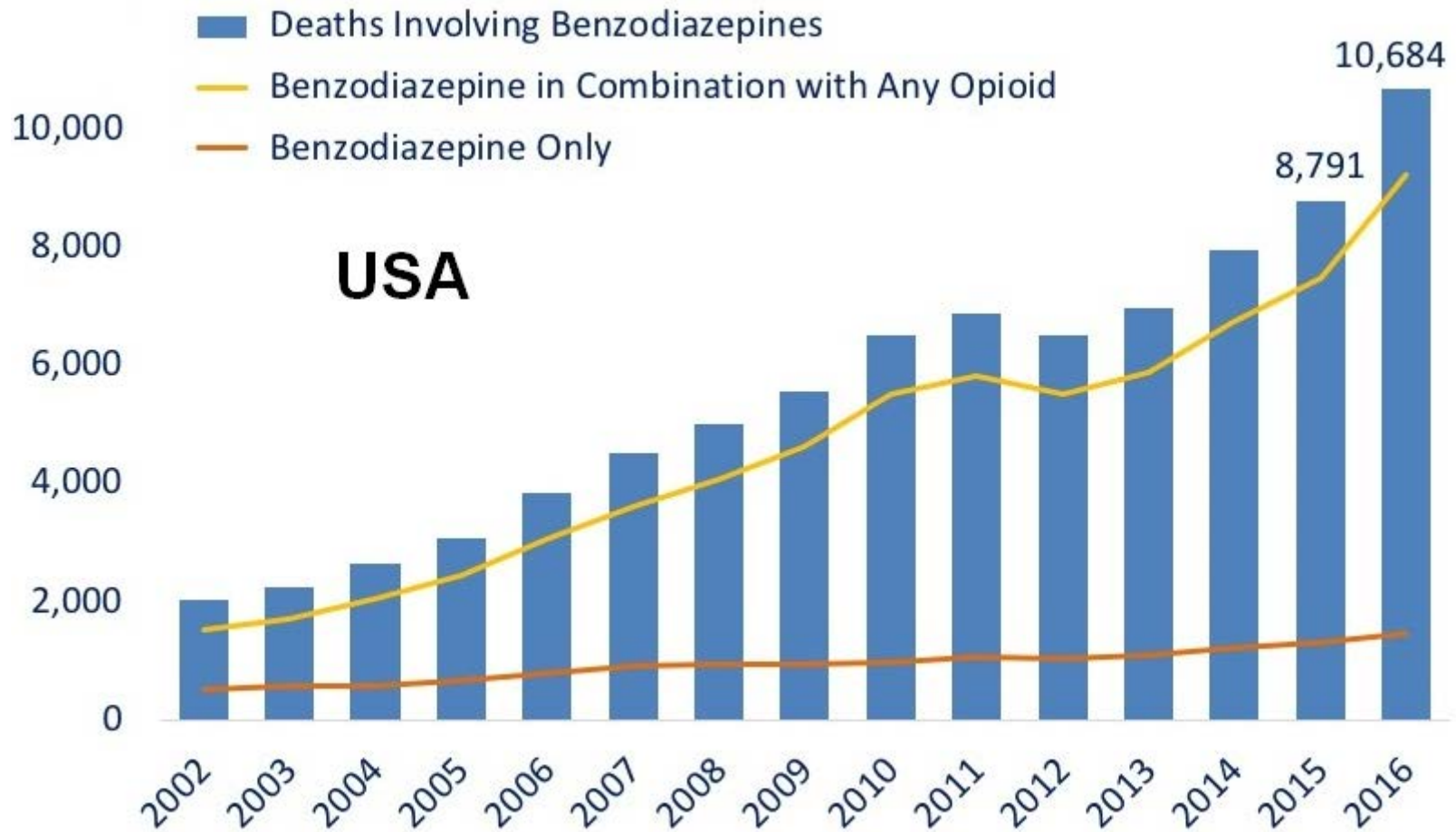


Two thirds of those using opioid medications for 90 days continue to use them long term (>2 years)

Opioid Addiction Risk For New Prescriptions



Opioids And Benzodiazepines



Source: National Center for Health Statistics, CDC Wonder

CalOptima Opioid Interventions

- Formulary restriction
 - Require prior authorization for new starts of drugs with the highest risk of overdose
 - Methadone
 - Extended-release high-dose morphine
 - Require prior authorization for short-acting opioid analgesic combinations exceeding formulary quantity limits
- Drug utilization review (DUR) point-of-service pharmacy edits
 - Cumulative morphine milligram equivalent (MME) pharmacy edits
 - 90 MME pharmacy edit overridable by the dispensing pharmacy (soft edit)
 - 200 MME pharmacy edit non-overridable by the dispensing pharmacy (hard edit) OC/OCC
 - 400 MME pharmacy edit non-overridable by the dispensing pharmacy (hard edit) Medi-Cal

CalOptima Opioid Interventions (cont.)

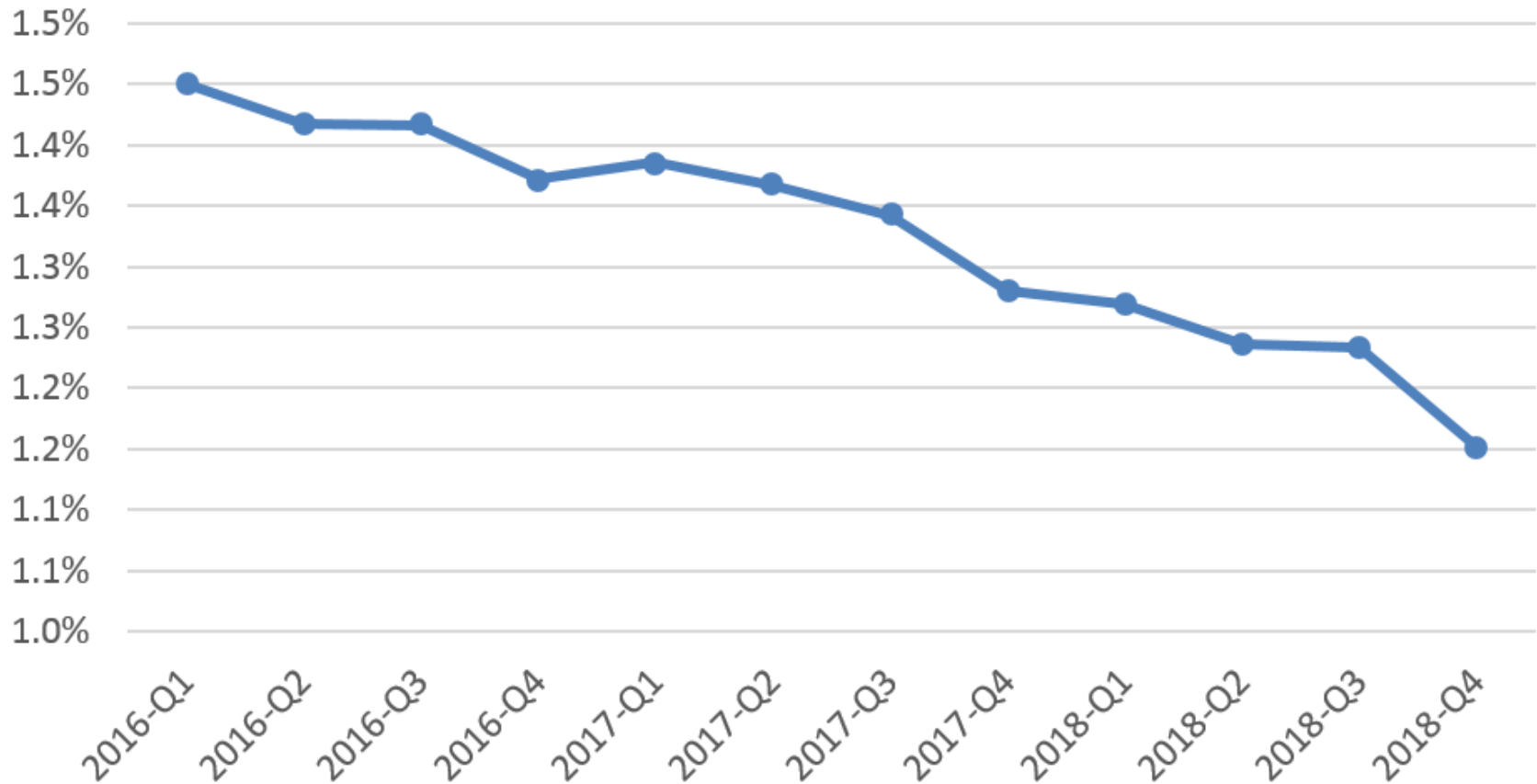
- Drug utilization review (DUR) point-of-service pharmacy edits (cont.)
 - Concomitant opioid analgesic/benzodiazepine pharmacy edit overridable by the dispensing pharmacy (soft edit)
- Member interventions
 - Pharmacy Home Program: CalOptima Medi-Cal members filling prescriptions at four or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year
 - Provider Restriction Program: Members that have filled controlled substance prescriptions from four or more prescribers in a two-month period: Prior authorization required for controlled substance prescriptions not written by the member's designated prescriber
 - Case Management and opioid interdisciplinary care team

CalOptima Opioid Interventions (cont.)

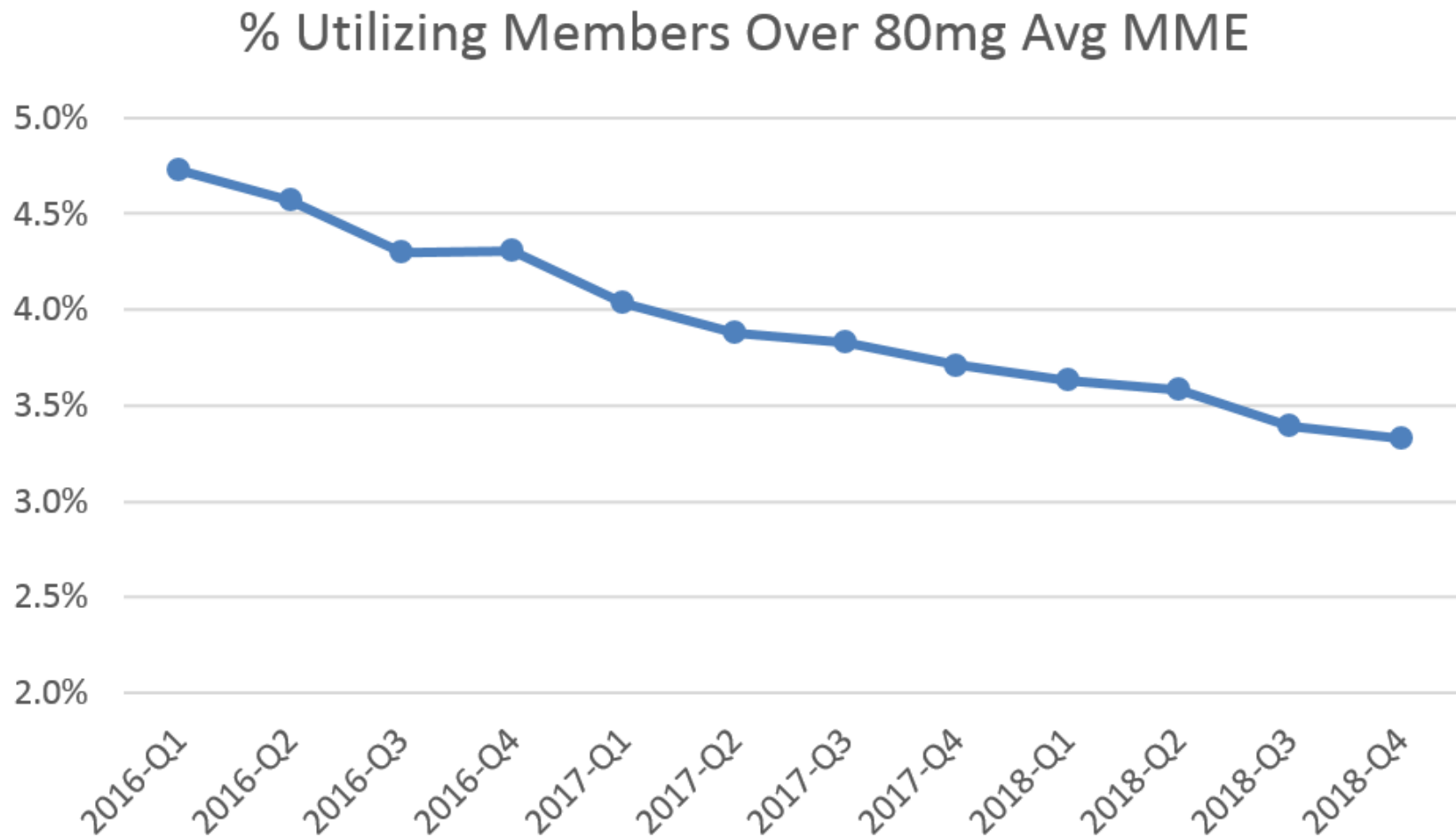
- Prescriber interventions
 - High volume/high MME prescriber quarterly report cards
 - Education programs
- Quality initiatives
 - Retrospective identification of opioid overutilization for Medical Director review
 - HEDIS and CMS Star measures

CalOptima Opioid Utilization

% of Members Utilizing Opioid Analgesics



CalOptima Opioid Utilization (cont.)



CalOptima Opioid Utilization (cont.)

Substance Use Disorders: All LOB	2018- Q1	2018- Q2	2018- Q3	2018- Q4
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.7	16.9
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521

What Else Can Be Done?

- Improve opioid prescribing
 - CDC's Guideline for Prescribing Opioids for Chronic Pain
 - CURES monitoring requirement
- Prevent opioid use disorders
 - Facilitating conversations with patients about the risks and benefits of pain treatment options
 - Patient education, including the safe storage and disposal of prescription opioids

What Else Can Be Done?

- Treat opioid use disorders
 - Medication Assisted Treatment (MAT)
 - Buprenorphine (Suboxone)
 - Naltrexone (Vivitrol)
 - Methadone
 - Counseling and behavioral therapies
- Reverse overdose to prevent death: Expand access to Naloxone (Narcan)

CalOptima's Mission

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



California State Budget: FY 2019-20 Proposal Analysis and CalOptima Impacts

January 2019

Overview

On January 10, 2019, Governor Gavin Newsom released his 2019-20 state budget proposal. The total budget proposed is \$209 billion, with General Fund spending at \$144 billion, which is flat compared to current year spending. The budget anticipates that the state's economy and associated revenues will grow at a modest rate, approximately 3.5 percent, which is lower than previous expectations, but still enough to drive an ambitious policy agenda.

Specific to health policy, Gov. Newsom put forward major changes soon after his inauguration on January 7. He announced a plan to expand Medi-Cal to cover undocumented young adults, proposed a statewide individual health insurance mandate and issued an Executive Order to consolidate pharmacy purchasing in order to lower drug costs. He also sent a letter to Congress and the Administration requesting that the Federal Government grant California the regulatory and statutory flexibility required to implement a single-payer system, stating that it does not have the latitude to do so under current law.¹ The budget proposal provides additional detail regarding some of these potential changes.

The Medi-Cal Budget

The increase in General Fund dollars allocated to Medi-Cal funding (see table 1 below) is based on an estimated Medi-Cal enrollment of 13.2 million members in fiscal year (FY) 2019-20.²

FY 2019–20 Proposed Medi-Cal Budget³

General Fund	\$22.9 billion (10.6 percent increase from 2018-19)
Federal Funds	\$62.7 billion (includes \$19.9 billion for MCE) ⁴
Other	\$15.1 billion (includes \$1.05 million in Prop. 56 funds) ⁵
Total	\$100.8 billion

Please note that the federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as Medi-Cal classic, there is a 50/50 match. For the Medi-Cal expansion (MCE) population,

there is an enhanced federal match (93/7 for calendar year 2019 and 90/10 for calendar year 2020).⁶ For the Children's Health Insurance Program (CHIP) population, there is currently an 88/12 match.

Additional Proposition 56 Medi-Cal Funding

The "other" portion of the Medi-Cal budget, by and large, accounts for state dollars that are drawn from the special funds pool, which includes, for instance, tobacco tax revenue designated for Medi-Cal. A large portion of the revenue raised by Prop. 56's expansion of the tobacco tax, approved by California voters in November 2016, is designated for augmenting the state's Medi-Cal budget through supplemental payments for physicians and dentists, among other health care related expenditures. The budget proposes to maintain existing Prop. 56 supplemental payments to providers and create new programs funded by these revenues, which, including federal matching dollars, totals \$3.2 billion for FY 2019–20. One new Prop. 56 program would establish incentives for providers to increase or improve services in high-impact areas, such as behavioral health integration, prenatal/postpartum care or chronic disease management.

Pharmacy Services Carve-Out

One of the most impactful elements of Gov. Newsom's health policy agenda is the carve-out of prescription drugs from Medi-Cal managed care and the return of this benefit to fee-for-service (FFS), no sooner than January 1, 2021.⁷ While some additional information about this transition was in the budget proposal, many aspects are yet to be defined. The governor's Executive Order (N-01-19), announced immediately after his inauguration, requires the Department of Health Care Services (DHCS) to begin planning for the transition to FFS in order to boost the state's negotiating power with pharmaceutical companies. This is part of the governor's effort to address the rapidly rising cost of prescription drugs. However, numerous questions remain, including whether the state can strengthen its ability to negotiate more effectively with drug companies without a total carve-out of the pharmacy benefit. Carving pharmacy services out of Medi-Cal managed care is likely to result in serious unintended consequences, such as reduced care coordination,

inefficient drug utilization and a far greater administrative burden on the state. Given these considerable concerns, health plans are working with the Newsom Administration on this issue to point out potential challenges as well as suggest alternate solutions, while still supporting his overall goal of controlling pharmaceutical costs and increasing health care affordability.

Expanding Full-Scope Medi-Cal

The Budget proposal includes a provision to expand full-scope Medi-Cal to undocumented individuals between the ages of 19 to 25, no sooner than July 1, 2019.⁸ According to DHCS, by the end of the first year of implementation, this expansion would result in an estimated 138,000 newly eligible individuals receiving full-scope benefits at a cost of \$194 million to the state's General Fund (\$260 million total). Of note, two companion bills were recently introduced in the legislature – Assembly Bill (AB) 4 and Senate Bill (SB) 29 – that would expand full-scope Medi-Cal to cover undocumented individuals regardless of age. Analyses of AB 4/SB 29's enrollment and fiscal impacts are not currently available, but are likely to be produced as these bills proceed through the legislative process.

Managed Care Organizations (MCO) Tax

Also of note, the budget proposal assumes the sunset of the MCO Tax.⁹ The MCO Tax is one of the financing mechanisms that the State of California utilizes to obtain increased federal funding to support the Medi-Cal program. The current iteration of the MCO tax, which became effective in July 2016 via a Centers for Medicare & Medicaid Services (CMS) waiver process, will sunset on June 30, 2019. Extending it would require reauthorization from the State Legislature and approval from CMS.¹⁰ The health insurance industry in California has supported participation in the MCO tax, as it has resulted in substantial revenue streams for health care programs. Specifically, the MCO tax results in more than \$1 billion in annual funding for the Medi-Cal program, as well as \$300 million in funding to support services for people with developmental disabilities. Notably, there were

complexities associated with enacting the current MCO tax, as CMS required that it must meet new criteria, based on Medicaid financing provisions in the Social Security Act. Our state trade associations, California Association of Health Plans (CAHP), and Local Health Plans of California (LHPC) have begun discussions with key stakeholders, including legislators and state officials, to look at options for a potential renewal of the MCO tax, taking into account the criteria that was used to ensure the passage of its current iteration. Of note, Senator Richard Pan, Chair of the Senate Health Committee, Assembly Member Jim Wood, Chair of the Assembly Committee on Health, and officials from the state Department of Finance have all recently indicated their willingness to consider a MCO tax extension.¹¹

Next Steps

Many of these policy changes are predicated on the new administration's expectation that the state's economy will experience moderate growth in the next fiscal year. The Governor's May Revise of the budget proposal could include adjustments based on a revised economic outlook or potential federal policy changes. We will continue to follow these proposals closely as they move through the budget process. Also, both the expansion of full-scope Medi-Cal and the Prop. 56 changes would require legislation to implement. Specific to the expansion, DHCS will propose trailer bill language to implement this change and it is likely to be dependent on systems changes and network readiness approvals being in place prior to implementation.

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

About CalOptima

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

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

Silver Ho

Compliance Officer, Office of Compliance
657-235-6997; sho@caloptima.org

Shamiq Hussain

Senior Policy Analyst, Government Affairs
714-347-3208; shussain@caloptima.org

Arif Shaikh

Director, Public Policy and Government Affairs
714-246-8418; ashaikh@caloptima.org

Jackie Mark

Senior Policy Analyst, Government Affairs
657-900-1157; jackie.mark@caloptima.org

Endnotes

¹ The Governor's Letter to Congress and the Administration is available at: <https://www.gov.ca.gov/wp-content/uploads/2019/01/1.7.19-Letter-to-the-White-House-and-Congress.pdf>

² Governor's Budget Summary 2019-20, p. 62

³ Department of Health Care Services, "2019-20 Governor's Budget Highlights," p. 14

⁴ Governor's Budget Summary 2019-20, p. 67

⁵ Ibid

⁶ Chernew, Michael. "The Economics of Medicaid Expansion," Health Affairs Blog, available at: <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>

⁷ Department of Health Care Services, "2019-20 Governor's Budget Highlights," p. 6

⁸ Governor's Budget Summary 2019-20, p. 65

⁹ Ibid, p. 70

¹⁰ Legislative Analyst's Office, "The 2019-20 Budget: Overview of the Governor's Budget," p. 12

¹¹ "California Should Extend Tax on Managed Care Organizations, Lawmakers Say," Politico Pro California, February 12, 2019, available at: <https://subscriber.politicopro.com/states/california/story/2019/02/12/california-should-extend-tax-on-managed-care-organizations-lawmakers-say-851571>



CalOptima
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California State Budget: FY 2019–20 Proposal

**Provider Advisory Committee
February 14, 2019**

**Arif Shaikh
Director, Public Policy and Government Affairs**

California Budget Overview

- Fiscal Year (FY) 2019–20
- Total Proposed Budget = \$209 billion
- General Fund = \$144 billion
- Budget Surplus = Approximately \$20 billion

Proposed Medi-Cal Budget

- Estimated enrollment of 13.2 million members

FY 2019–20 Proposed Medi-Cal Budget	
General Fund	\$22.9 billion
Federal Funds	\$62.7 billion
Other	\$15.1 billion
Total	\$100.7 billion

Funding Shares

- Medi-Cal Classic = 50/50 federal/state
- Medi-Cal Expansion
 - 2019 = 93/7 federal/state
 - 2020 = 90/10 federal/state
- Children's Health Insurance Program (CHIP) = 88/12 federal/state

Pharmacy Services Carve-Out

- Executive Order: Carve out pharmacy services from Medi-Cal managed care and return to fee-for-service
- No sooner than July 1, 2021
- Part of an effort to control drug costs
- Senate Budget Committee Informational Hearing on February 14, 2019

Additional Prop. 56 Funding

- Maintain existing Prop. 56 supplemental payments to providers
- Create new Prop. 56 programs
 - Example: Incentives for providers to increase or improve services in high-impact areas, such as behavioral health integration, prenatal/postpartum care or chronic disease management
 - Requires trailer bill language to implement
 - Program details pending

MCO Tax Sunset

- Budget proposal assumes the Managed Care Organization (MCO) Tax sunset on June 30, 2019
 - MCO Tax brought in approximately \$1 billion/year for Medi-Cal
- Key legislators are interested in extending the MCO Tax
 - Sen. Richard Pan, Chair, Senate Health
 - Assemblyman Jim Wood, Chair, Assembly Health

Expanding Full-Scope Medi-Cal

- Expand full-scope Medi-Cal to undocumented individuals up to age 25
- No sooner than July 1, 2019
- DHCS estimates:
 - 138,000 newly eligible individuals
 - \$194 million General Fund cost in FY 2019–20
- AB 4/SB 29: Expand full-scope Medi-Cal to all undocumented individuals

Next Steps

- Governor's January budget proposal is just the first step
- Legislature will now begin holding budget hearings
- Governor will release the May Revise
- Legislature then has until June 15 to pass a final state budget
- Governor has until June 30 to sign

CalOptima's Mission

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

Denti-Cal Initiative

Provider Advisory Committee
February 14, 2019

Arif Shaikh
Director, Public Policy and Government Affairs

Agenda

- Background
- Opportunity
- Exploration
- Next Steps

Background

- The Department of Health Care Services (DHCS) is responsible for administering dental benefits for Medi-Cal beneficiaries through a system separate (“carved out”) from medical benefits
- Dental benefits are administered by Denti-Cal using two different models
 - Fee-for-Service (FFS): Beneficiaries receive dental services from any licensed Denti-Cal-enrolled provider who accepts Denti-Cal payments and agrees to see them
 - Dental Managed Care (DMC): Medi-Cal pays dental plans a set amount per member per month, and members are only allowed to receive services from providers within the plan’s network

Background (Cont.)

- The Little Hoover Commission issued a scathing 2016 report about FFS Denti-Cal
 - Denti-Cal is “broken, bureaucratically rigid and unable to deliver the quality of dental care most other Californians enjoy.”
 - Utilization of dental benefits for Medi-Cal members is low, due primarily to a shortage of dental providers who participate in Denti-Cal

Background (Cont.)

- Currently, two California counties have DMC
 - Sacramento County: DMC model is mandatory, and Medi-Cal beneficiaries are mandatorily enrolled in a DMC plan
Beneficiaries, however, may opt out of a DMC plan and move to a FFS Denti-Cal plan
 - Los Angeles County: Beneficiaries are automatically enrolled in FFS Denti-Cal and must opt in to participate in a DMC plan
- San Mateo County scheduled to launch DMC in July 2019
 - Gov. Brown signed State Bill 849 on June 27, 2018, authorizing a dental integration pilot program with Health Plan of San Mateo
 - Pilot is designed to test the impact on access, quality, utilization and cost when dental care is a managed care benefit

Opportunity

- CalOptima is committed to ensuring the health and well-being of our community
 - Track record of collaborating with providers, regulators and other stakeholders to improve the local delivery system
 - Ample experience at integrating programs and realizing better access and improved care coordination for members
- On November 1, 2018, CalOptima's Board of Directors authorized staff to explore policy opportunities to carve in dental benefits for Orange County Medi-Cal members

Exploration

- CalOptima staff will take a three-pronged approach to exploring the policy opportunity to carve in dental benefits
 1. Engage local stakeholders, including the Orange County Dental Society, to discuss opportunities for CalOptima to develop a dental provider network that increases access to dental care for Medi-Cal members
 2. Engage regulators and statewide advocacy organizations, including DHCS and the California Dental Association, to determine their level of support for policy solutions that integrate dental benefits into Medi-Cal managed care in Orange County
 3. Engage members of the Orange County delegation to identify opportunities through the state legislative process

Engage Local Stakeholders

- CalOptima is now working to gather feedback from local stakeholders who understand the needs of the community
- CalOptima will be seeking letters of support from organizations that share our interest in integration
 - Response is requested by March 1, so CalOptima can further discussions with regulators and state advocacy groups

CalOptima's Mission

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

