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

THURSDAY, MARCH 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 February 14, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

V. REPORTS

A. Consider Recommendation of Provider Advisory Committee Hospital Representative Candidate

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. Homeless Health Update
B. Behavioral Health Update
C. Proposed Health Network Quality Performance Rating Methodology
D. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

Back to Agenda

MINUTES

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

February 14, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, February 14, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

John Nishimoto, O.D., PAC Chair, reordered the agenda to hear CEO and Management Reports until a quorum was reached.

PUBLIC COMMENTS

Pamela Pimentel, MOM's of Orange County, Oral re: Agenda Item VII. D., Update on Dental Initiatives

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), presented an update on the Whole-Child Model (WCM) contracting initiative and noted that CalOptima will be providing the Department of Health Care Services (DHCS) with copies of signed provider contracts before March 1, 2019. She noted that member noticing is still required, and members will receive both a 90-day and a 60-day letter as well as outreach calls. Ms. Khamseh also updated the PAC on the Health Homes Program and noted that CalOptima is working with the DHCS to see if there is flexibility in pushing out the roll out of this program to January 1, 2020. Ms. Khamseh also updated the PAC on the Board approved process for considering requests for letters of support from organizations seeking to offer Program of All-Inclusive Care for the Elderly (PACE) services in the Orange County area and noted that there were two letters of support being reviewed as per the Board's directive at the September 2018 meeting.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), provided an update on medical management and pharmacy management's plan to reduce barriers for the WCM families and members to receive care. He noted that these departments are working diligently to ensure that the roll out on July 1, 2019 goes smoothly. Dr. Ramirez also discussed Homeless Health and ways CalOptima could help support members who are homeless by trying to identify gaps in care with the homeless population. He also updated the PAC on the Be Well OC Center and how the Center could assist members in such areas as dementia and eating disorders.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, noted that the DHCS is slated to certify the provider network for the WCM by March 15, 2019. She noted that ten networks were using Children's Hospital of Orange County (CHOC) to create their WCM network. Ms. Laughlin also noted that physicians who had applied for their Medi-Cal enrollment were being notified by DHCS of their acceptance into the Medi-Cal program.

Back to Agenda

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:20 a.m. Vice Chair Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D. (at 8:20 a.m.); Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.
Members Absent:	Theodore Caliendo, M.D., Junie Lazo-Pearson, Ph.D., Brian Lee, Ph.D. and Jacob Sweidan, M.D.
Others Present:	Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the December 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 December 13, 2018 meeting. (Motion carried 8-0-0; Members Caliendo, Lazo-Pearson, Lee and Sweidan absent)***

INFORMATION ITEMS

Opioid Crisis Update

Dr. Ramirez presented an update on the opioid crisis in Orange County. He noted that CalOptima had instituted some formulary restriction that required prior authorization for drugs with the highest risk of overdose such as Methadone and extended-release high-dose morphine as well as require a prior authorization for short-acting opioid analgesic combinations exceeding formulary quantity limits. Dr. Ramirez noted that CalOptima's pharmacy management team currently works with members who have been prescribed opioids and the physicians who are prescribing them by providing member and physician education.

Back to Agenda

Health Homes Program Update

Candice Gomez, Executive Director, Program Implementation, provided an update on the Health Homes Program (HHP) and noted that the required DHCS readiness documents and deliverables have been submitted to DHCS for review and approval Ms. Gomez informed the committee that CalOptima has requested the HHP be effective January 1, 2020 not July 1, 2019. DHCS has not yet responded to the request.

State Budget Update

Arif Shaikh, Director, Government Affairs, provided an update on newly elected Governor Newsom's budget proposals. He noted that the proposed budget would carve-out pharmacy services and return it to fee-for-service no sooner than July 1, 2021, in an effort to control drug costs. The Senate Budget Committee is holding an informational hearing on February 14, 2019. Mr. Shaikh also discussed the Managed Care Organization (MCO) Tax, which is due to end on June 30, 2019. He noted that there is interest in extending the MCO tax, which brings in approximately $1 billion/year for Medi-Cal. Mr. Shaikh also discussed the State's intent to expand full scope Medi-Cal to undocumented individuals up to age 25.

Update on Dental Initiatives

Mr. Shaikh presented an update on the Denti-Cal Initiative and provided the PAC with a brief background on the program. Mr. Shaikh noted that at the November 1, 2018 Board of Directors meeting, the Board authorized CalOptima to explore policy opportunities to carve-in dental benefits for Orange County Medi-Cal members. He noted that CalOptima will start to engage local stakeholders, regulators and statewide advocacy organizations, including DHCS and the California Dental Association, to determine their level of support. CalOptima is seeking letters of support from organizations that share CalOptima's interest in the integration of the dental program into Medi-Cal. Letters of support are due by March 1, 2019.

PAC Member Updates

On behalf of the PAC, Chair Nishimoto recognized former member Pamela Pimentel for her nine years of service on the PAC. Ms. Pimentel thanked the PAC members, CalOptima leadership and staff for their support during her tenure.

Chair Nishimoto noted that the recruitment for the hospital and nurse representatives will close on Friday, February 15, 2019. Chair Nishimoto requested volunteers for a Recruitment Ad Hoc Committee to review the applicants for the hospital and nurse representatives' seats, and Vice Chair Miranti and Members Myers and Sweidan volunteered to serve. The ad hoc will present recommendations for consideration at the March 14, 2019 meeting.

Back to Agenda

ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 9:38 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: March 14, 2019

Back to Agenda

MEMORANDUM

DATE:	March 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

Special Board Meeting Approves Immediate Action on Homeless Health Initiatives
In response to your Board's special meeting on February 22, I will be presenting an Information Item at the March 7 meeting to summarize Board-authorized actions related to homeless health, including our clinical field team pilot program and CalOptima Homeless Response Team, as well as follow up on additional initiatives proposed by Supervisor Andrew Do and county representatives. These include ideas that address both physical health improvements and Whole-Person Care/housing.

CalOptima Focuses Advocacy Efforts on Detrimental Licensure Proposal
On February 13, CalOptima helped arrange meetings with the governor's office and legislators to express concern about the Department of Managed Health Care (DHMC) General Licensure proposed regulation. A group of leaders representing the California Medical Association, California Hospital Association, California Association of Health Plans, Local Health Plans of California and America's Physician Groups came together to respond to the proposal, which says that any entity that takes "global risk" (i.e., risk for both physician and hospital services) from a full-service health plan would be required to obtain a Knox-Keene license or seek an exemption. During our meeting with the governor's Deputy Cabinet Secretary Richard Figueroa, the coalition questioned the broad definition of global risk and the undefined criteria for obtaining an exemption. With a collective voice, we asked that the governor pull back the proposed regulation and initiate a stakeholder process so concerns can be addressed. To extend the impact of the governor's office meeting, I met with five members of our Orange County delegation, including Assemblywoman Sharon Quirk-Silva, Assemblyman Phillip Chen, Assemblyman Tyler Diep, Sen. John Moorlach and Sen. Tom Umberg. I briefed them on the concerns with the DMHC proposed rule.

More recently, the California Hospital Association worked with Sen. Umberg to introduce SB 714, a bill that may address the concerns with the proposed regulation. The bill will be considered next by the Senate Health Committee.

Meetings With State Officials Address Proposed Change to Pharmacy Benefits
In January, Gov. Gavin Newsom issued an executive order calling for the transition of Medi-Cal pharmacy benefits from managed care to fee-for-service (FFS). To raise awareness about the member impact of a FFS pharmacy program, CalOptima, L.A. Care and Inland Empire Health Plan leaders participated in a series of Sacramento meetings on February 26 arranged by Local

Back to Agenda

Health Plans of California and California Association of Health Plans. The group met representatives from the Assembly Republican Caucus, Senate Budget Committee, Senate Republican Caucus and the governor's office to make suggestions about alternate ways to achieve reduced pharmacy costs without affecting the managed care system already in place for more than 10 million Medi-Cal members statewide.

Programs Supporting Quality Care Are Ready for New Fiscal Year

Quality care for members is central to our mission. This month, your Board is considering two items that set quality priorities for Fiscal Year 2019–20. These programs were thoroughly reviewed and approved in advance by your Quality Assurance Committee on February 20. The 2019 Quality Improvement Program and Work Plan incorporates new initiatives, including Whole-Person Care, Whole-Child Model, Health Homes and population health management. The overall goal is to improve our National Committee for Quality Assurance rating from 4.0 to 4.5 by 2021, with special attention on bettering our member experience scores. Also before your Board is the Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance and Performance Improvement Plan. New elements of the PACE plan focus on comprehensive diabetes care, reduced use of high-dose opioids, decreased day center falls, increased satisfaction with center meals and more.

CalOptima Successfully Completes Transition to Single Retirement Plan Vendor

To streamline and enhance retirement plan options for employees, CalOptima recently transitioned from two 457(b) deferred compensation plan vendors to a single vendor, Empower Retirement. More than 460 employees participate in the plan, which is the public agency equivalent of a 401(k) program at a private business. Selected through a competitive process, Empower is one of the nation's largest retirement product companies. CalOptima does not contribute to 457(b) plans on behalf of employees; all employee contributions are voluntary.

Back to Agenda

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Financial Summary

January 2019

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2018-19: Consolidated Enrollment

- January 2019 MTD:
  - Overall enrollment was 763,906 member months
    - Actual lower than budget 19,896 or 2.5%
      - Medi-Cal: unfavorable variance of 19,449 members
        - Whole Child Model (WCM) unfavorable variance of 12,502 members
        - Medi-Cal Expansion (MCE) unfavorable variance of 6,594 members
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 1,716 members
        - Seniors and Persons with Disabilities (SPD) favorable variance of 1,462 members
        - Long-Term Care (LTC) unfavorable variance of 99 members
      - OneCare Connect: unfavorable variance of 569 members
    - 2,288 decrease from December
      - Medi-Cal: decrease of 2,297 from December
      - OneCare Connect: decrease of 14 from December
      - OneCare: increase of 18 from December
      - PACE: increase of 5 from December

FY 2018-19: Consolidated Enrollment (cont.)

- January 2019 YTD:
  - Overall enrollment was 5,400,977 member months
    - Actual lower than budget 89,986 members or 1.6%
      - Medi-Cal: unfavorable variance of 88,476 members or 1.6%
        - TANF unfavorable variance of 40,300 members
        - MCE unfavorable variance of 34,478 members
        - WCM unfavorable variance of 12,502 members
        - SPD unfavorable variance of 685 members
        - LTC unfavorable variance of 511 members
      - OneCare Connect: unfavorable variance of 2,105 members or 2.0%
      - OneCare: favorable variance of 596 members or 6.4%
      - PACE: unfavorable variance of 1 member or 0.0%

FY 2018-19: Consolidated Revenues

- January 2019 MTD:
  - ➢ Actual lower than budget $17.3 million or 5.8%
    - Medi-Cal: unfavorable to budget $13.7 million or 5.1%
      - Unfavorable volume variance of $6.8 million
      - Unfavorable price variance of $6.9 million
    - OneCare Connect: unfavorable to budget $3.6 million or 13.4%
      - Unfavorable volume variance of $1.0 million
      - Unfavorable price variance of $2.6 million
    - OneCare: Unfavorable to budget $10.3 thousand or 0.6%
      - Favorable volume variance of $162.1 thousand
      - Unfavorable price variance of $172.4 thousand
    - PACE: Unfavorable to budget $789 or 0.0%
      - Unfavorable volume variance of $51.0 thousand
      - Favorable price variance of $50.2 thousand

FY 2018-19: Consolidated Revenues (cont.)

- January 2019 YTD:
  - Actual lower than budget $41.3 million or 2.1%
    - Medi-Cal: unfavorable to budget $38.8 million or 2.2%
      - Unfavorable volume variance of $28.9 million
      - Unfavorable price variance of $9.9 million due to:
        - $22.9 million of WCM revenue
        - $9.5 million of FY19 non-LTC revenue from non-LTC aid codes
        - $4.9 million of Proposition 56 revenue
        - $2.0 million of FY19 Behavioral Health Treatment (BHT) revenue
        - Offset by favorable variance due to:
          - $16.0 million due to favorable rates
          - $3.1 million of Coordinated Care Initiative (CCI) revenue
          - $2.8 million of Hepatitis C revenue
          - $4.5 million of prior year (PY) non-LTC revenue from non-LTC aid codes
          - $1.5 million of PY CCI revenue
          - $1.1 million of PY BHT revenue

FY 2018-19: Consolidated Revenues (cont.)

- January 2019 YTD:
  - ➢OneCare Connect: unfavorable to budget $2.1 million or 1.2%
    - Unfavorable volume variance of $3.6 million
    - Favorable price variance of $1.4 million
  - ➢OneCare: unfavorable to budget $0.4 million or 3.8%
    - Favorable volume variance of $0.7 million
    - Unfavorable price variance of $1.2 million due to:
      - $0.3 million calendar year (CY) 2015 risk adjustment
      - $1.0 million CY 2016 Hierarchical Condition Categories (HCC) risk adjustment
  - ➢PACE: favorable to budget $50.0 thousand or 0.3%
    - Unfavorable volume variance of $7.3 thousand
    - Favorable price variance of $57.1 thousand

FY 2018-19: Consolidated Medical Expenses

- January 2019 MTD:
  - ➢ Actual lower than budget $25.7 million or 8.9%
    - ▪ Medi-Cal: favorable variance of $24.7 million
      - Favorable volume variance of $6.6 million
      - Favorable price variance of $18.2 million
        - ➢ Provider Capitation expenses favorable variance of $4.7 million due to Proposition 56 and Child Health and Disability Prevention Program (CHDP) expenses that were budgeted in Professional Claims
        - ➢ Professional Claim expenses favorable variance of $4.6 million due to:
          - CHDP expenses of $2.0 million
          - BHT expenses of $2.5 million
          - Proposition 56 expenses of $2.6 million and Non-Medical Transportation (NMT), offset by Incurred But Not Reported (IBNR) expense of $2.5 million
        - ➢ Prescription Drug expenses favorable variance of $4.2 million
        - ➢ Facilities expenses favorable variance of $3.6 million

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

- January 2019 MTD:
  - ➢ OneCare Connect: favorable variance of $810.0 thousand or 3.2%
    - Favorable volume variance of $974.1 thousand
    - Unfavorable price variance of $164.0 thousand
  - ➢ OneCare: favorable variance of $79.3 thousand or 5.0%
  - ➢ PACE: favorable variance of $59.5 thousand or 2.8%

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

- January 2019 YTD:
  - Actual lower than budget $66.0 million or 3.5%
    - Medi-Cal: favorable variance of $64.0 million
      - Favorable volume variance of $27.6 million
      - Favorable price variance of $36.4 million
        - Professional Claim expenses favorable variance of $42.5 million
        - Provider Capitation expenses unfavorable variance of $18.0 million
        - Prescription Drug expenses favorable variance of $16.9 million
        - Facilities expenses unfavorable variance of $13.8 million
        - Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $8.1 million
    - OneCare Connect: favorable variance of $0.7 million
      - Favorable volume variance of $3.4 million
      - Unfavorable price variance of $2.8 million
- Medical Loss Ratio (MLR):
  - January 2019 MTD: Actual: 92.9% Budget: 96.1%
  - January 2019 YTD: Actual: 94.0% Budget: 95.4%

Back to Agenda

FY 2018-19: Consolidated Administrative Expenses

- January 2019 MTD:
  - Actual lower than budget $0.8 million or 6.0%
    - Salaries, wages and benefits: favorable variance of $0.6 million
    - Other categories: favorable variance of $0.2 million

- January 2019 YTD:
  - Actual lower than budget $15.5 million or 17.5%
    - Salaries, wages & benefits: favorable variance of $7.8 million
    - Other categories: favorable variance of $7.7 million

- Administrative Loss Ratio (ALR):
  - January 2019 MTD: Actual: 4.3% Budget: 4.3%
  - January 2019 YTD: Actual: 3.8% Budget: 4.5%

FY 2018-19: Change in Net Assets

- January 2019 MTD:
  - $11.9 million surplus
  - $12.9 million favorable to budget
    - Lower than budgeted revenue of $17.3 million
    - Lower than budgeted medical expenses of $25.7 million
    - Lower than budgeted administrative expenses of $0.8 million
    - Higher than budgeted investment and other income of $3.8 million

- January 2019 YTD:
  - $63.0 million surplus
  - $58.3 million favorable to budget
    - Lower than budgeted revenue of $41.3 million
    - Lower than budgeted medical expenses of $66.0 million
    - Lower than budgeted administrative expenses of $15.5 million
    - Higher than budgeted investment and other income of $18.0 million

Enrollment Summary: January 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
64,506	65,115	(609)	(0.9%)	Aged	448,459	451,101	(2,642)	(0.6%)
596	620	(24)	(3.9%)	BCCTP	4,243	4,340	(97)	(2.2%)
46,213	44,118	2,095	4.7%	Disabled	328,931	326,877	2,054	0.6%
305,194	304,863	331	0.1%	TANF Child	2,167,238	2,197,338	(30,100)	(1.4%)
91,564	93,611	(2,047)	(2.2%)	TANF Adult	653,142	663,344	(10,200)	(1.5%)
3,416	3,515	(99)	(2.8%)	LTC	23,863	24,374	(511)	(2.1%)
236,373	242,967	(6,594)	(2.7%)	MCE	1,661,125	1,695,603	(34,478)	(2.0%)
-	12,502	(12,502)	(100.0%)	WCM	-	12,502	(12,502)	(100.0%)
747,862	**767,311**	**(19,449)**	**(2.5%)**	**Medi-Cal**	**5,287,001**	**5,375,477**	**(88,476)**	**(1.6%)**
14,287	**14,856**	**(569)**	**(3.8%)**	**OneCare Connect**	**102,080**	**104,185**	**(2,105)**	**(2.0%)**
304	**311**	**(7)**	**(2.3%)**	**PACE**	**2,032**	**2,033**	**(1)**	**(0.0%)**
1,453	**1,324**	**129**	**9.7%**	**OneCare**	**9,864**	**9,268**	**596**	**6.4%**
763,906	**783,802**	**(19,896)**	**(2.5%)**	**CalOptima Total**	**5,400,977**	**5,490,963**	**(89,986)**	**(1.6%)**

Back to Agenda

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Financial Highlights: January 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
763,906	783,802	(19,896)	-2.5%	Member Months	5,400,977	5,490,963	(89,986)	-1.6%
282,356,609	299,659,541	(17,302,931)	-5.8%	Revenues	1,919,123,046	1,960,439,140	(41,316,094)	-2.1%
262,370,973	288,061,736	25,690,763	8.9%	Medical Expenses	1,804,071,969	1,870,090,834	66,018,866	3.5%
12,226,927	13,001,814	774,887	6.0%	Administrative Expenses	73,054,159	88,573,258	15,519,100	17.5%
7,758,709	**(1,404,009)**	**9,162,718**	**652.6%**	**Operating Margin**	**41,996,918**	**1,775,047**	**40,221,872**	**2266.0%**
4,183,226	416,667	3,766,559	904.0%	Non Operating Income (Loss)	20,959,745	2,916,667	18,043,079	618.6%
11,941,934	**(987,342)**	**12,929,277**	**1309.5%**	**Change in Net Assets**	**62,956,664**	**4,691,714**	**58,264,950**	**1241.9%**
92.9%	96.1%	3.2%		Medical Loss Ratio	94.0%	95.4%	1.4%	
4.3%	4.3%	0.0%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
2.7%	-0.5%	3.2%		Operating Margin Ratio	2.2%	0.1%	2.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

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Consolidated Performance Actual vs. Budget: January 2019 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
11.0	(0.7)	11.7	Medi-Cal	47.9	9.2	38.8
(3.3)	(0.6)	(2.7)	OCC	(7.0)	(7.0)	(0.0)
0.0	(0.0)	0.1	OneCare	(0.4)	(0.5)	0.1
0.0	(0.0)	0.1	PACE	1.5	0.0	1.4
7.8	**(1.4)**	**9.2**	**Operating**	**42.0**	**1.8**	**40.2**
4.2	0.4	3.8	Inv./Rental Inc, MCO tax	21.0	2.9	18.0
4.2	**0.4**	**3.8**	**Non-Operating**	**21.0**	**2.9**	**18.0**
11.9	**(1.0)**	**12.9**	**TOTAL**	**63.0**	**4.7**	**58.3**

Consolidated Revenue & Expense: January 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	511,489	236,373	747,862	14,287	1,453	304	763,906
REVENUES							
Capitation Revenue	$ 145,620,329	$ 109,655,200	$ 255,275,529	$ 23,164,191	$ 1,653,636	$ 2,263,254	$ 282,356,609
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	145,620,329	109,655,200	255,275,529	23,164,191	1,653,636	2,263,254	282,356,609
MEDICAL EXPENSES							
Provider Capitation	37,039,406	50,179,231	87,218,637	11,106,778	459,414		98,784,829
Facilities	19,863,002	22,046,572	41,909,574	4,366,250	408,804	538,043	47,222,671
Ancillary	-	-	-	611,315	11,451	-	622,766
Professional Claims	17,001,935	7,044,057	24,045,992	-	-	508,229	24,554,221
Prescription Drugs	18,978,651	21,370,752	40,349,402	5,618,682	519,563	200,769	46,688,416
MLTSS	32,670,939	2,835,555	35,506,494	1,224,594	5,807	(1,532)	36,735,362
Medical Management	2,206,114	1,070,898	3,277,012	1,249,973	86,356	664,989	5,278,331
Quality Incentives	759,431	408,704	1,168,135	269,600			1,437,735
Reinsurance & Other	421,754	286,720	708,474	174,329	6,000	157,839	1,046,642
Total Medical Expenses	128,941,233	105,242,488	234,183,721	24,621,520	1,497,395	2,068,337	262,370,973
Medical Loss Ratio	88.5%	96.0%	91.7%	106.3%	90.6%	91.4%	92.9%
GROSS MARGIN	**16,679,096**	**4,412,712**	**21,091,808**	**(1,457,330)**	**156,241**	**194,917**	**19,985,636**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,812,348	860,958	44,461	108,568	7,826,334
Professional fees			192,637	34,500	14,666	170	241,972
Purchased services			1,053,706	188,768	19,080	3,950	1,265,505
Printing & Postage			439,595	100,003	21,367	26,415	587,380
Depreciation & Amortization			383,366			2,068	385,434
Other expenses			1,572,234	42,098	113	2,168	1,616,613
Indirect cost allocation & Occupancy			(333,078)	589,123	44,020	3,624	303,689
Total Administrative Expenses			10,120,808	1,815,450	143,708	146,962	12,226,927
Admin Loss Ratio			4.0%	7.8%	8.7%	6.5%	4.3%
INCOME (LOSS) FROM OPERATIONS			10,971,000	(3,272,779)	12,533	47,955	7,758,709
INVESTMENT INCOME							4,186,441
TOTAL GRANT INCOME			(3,263)				(3,263)
OTHER INCOME			47				47
CHANGE IN NET ASSETS			**$ 10,967,784**	**$ (3,272,779)**	**$ 12,533**	**$ 47,955**	**$ 11,941,934**
BUDGETED CHANGE IN NET ASSETS			(721,019)	(588,423)	(46,136)	(48,431)	(987,342)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 11,688,804	$ (2,684,356)	$ 58,669	$ 96,386	$ 12,929,277

Back to Agenda

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Consolidated Revenue & Expense: January 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,625,876	1,661,125	5,287,001	102,080	9,864	2,032	5,400,977
REVENUES							
Capitation Revenue	$ 947,244,806	$ 772,640,871	$ 1,719,885,676	$ 173,661,596	$ 10,781,848	$ 14,793,926	$ 1,919,123,046
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	947,244,806	772,640,871	1,719,885,676	173,661,596	10,781,848	14,793,926	1,919,123,046
MEDICAL EXPENSES							
Provider Capitation	250,617,021	352,456,760	603,073,780	80,600,630	2,928,993		686,603,402
Facilities	155,920,856	161,585,639	317,506,494	24,312,845	3,069,414	2,722,641	347,611,394
Ancillary	-	-	-	4,488,570	208,812	-	4,697,382
Professional Claims	110,511,858	43,714,631	154,226,488	-	-	3,030,850	157,257,338
Prescription Drugs	120,434,324	136,766,363	257,200,687	37,928,693	3,264,409	1,162,702	299,556,492
MLTSS	223,949,657	19,553,554	243,503,211	9,995,834	443,922	26,948	253,969,915
Medical Management	14,768,603	7,243,876	22,012,478	7,842,823	440,669	4,376,911	34,672,880
Quality Incentives	5,384,701	2,863,430	8,248,131	2,102,200		17,280	10,367,611
Reinsurance & Other	4,102,469	2,472,946	6,575,415	1,580,245	43,095	1,136,800	9,335,556
Total Medical Expenses	885,689,487	726,657,197	1,612,346,685	168,851,839	10,399,314	12,474,131	1,804,071,969
Medical Loss Ratio	93.5%	94.0%	93.7%	97.2%	96.5%	84.3%	94.0%
GROSS MARGIN	**61,555,318**	**45,983,673**	**107,538,992**	**4,809,757**	**382,534**	**2,319,795**	**115,051,077**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			42,329,808	5,315,869	236,029	682,644	48,564,351
Professional fees			1,098,709	214,798	102,667	6,414	1,422,587
Purchased services			4,913,205	1,255,274	104,092	57,212	6,329,783
Printing & Postage			2,256,402	519,911	64,074	47,523	2,887,909
Depreciation & Amortization			2,804,082			14,561	2,818,644
Other expenses			8,305,625	303,776	377	17,526	8,627,305
Indirect cost allocation & Occupancy			(2,100,921)	4,209,300	263,597	31,604	2,403,580
Total Administrative Expenses			59,606,911	11,818,928	770,835	857,485	73,054,159
Admin Loss Ratio			3.5%	6.8%	7.1%	5.8%	3.8%
INCOME (LOSS) FROM OPERATIONS			47,932,081	(7,009,172)	(388,301)	1,462,310	41,996,918
INVESTMENT INCOME							20,959,002
OTHER INCOME			744				744
CHANGE IN NET ASSETS			**$ 47,932,825**	**$ (7,009,172)**	**$ (388,301)**	**$ 1,462,310**	**$ 62,956,664**
BUDGETED CHANGE IN NET ASSETS			9,167,131	(6,962,484)	(467,487)	37,886	4,691,714
VARIANCE TO BUDGET - FAV (UNFAV)			$ 38,765,693	$ (46,688)	$ 79,186	$ 1,424,424	$ 58,264,950

Back to Agenda

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Balance Sheet:
As of January 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$464,736,693	Accounts Payable	$16,470,762
Investments	396,601,507	Medical Claims liability	713,456,996
Capitation receivable	329,899,166	Accrued Payroll Liabilities	11,494,059
Receivables - Other	21,505,253	Deferred Revenue	85,552,175
Prepaid expenses	6,827,680	Deferred Lease Obligations	76,306
		Capitation and Withholds	122,901,013
Total Current Assets	**1,219,570,299**	**Total Current Liabilities**	**949,951,310**
Capital Assets			
Furniture & Equipment	35,575,437		
Building/Leasehold Improvements	8,311,770		
505 City Parkway West	50,013,815		
	93,901,022		
Less: accumulated depreciation	(45,196,085)		
Capital assets, net	48,704,938	Other (than pensions) post employment benefits liability	25,439,057
Other Assets		Net Pension Liabilities	24,985,897
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	39,485,056	**TOTAL LIABILITIES**	**1,000,376,264**
Long-term Investments	509,100,533		
Total Board-designated Assets	548,585,589	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	548,885,589		
TOTAL ASSETS	**1,817,160,825**	TNE	81,915,494
		Funds in Excess of TNE	742,672,737
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	824,588,231
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,828,293,875**	**TOTAL LIABILITIES & FUND BALANCES**	**1,828,293,875**

Back to Agenda

CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of January 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,062,296				
	Tier 1 - Logan Circle	149,850,498				
	Tier 1 - Wells Capital	149,456,359				
Board-designated Reserve		449,369,153	310,342,744	478,453,417	139,026,409	(29,084,264)
TNE Requirement	Tier 2 - Logan Circle	99,216,436	81,915,494	81,915,494	17,300,941	17,300,941
	Consolidated:	**548,585,589**	**392,258,238**	**560,368,911**	**156,327,351**	**(11,783,323)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

Back to Agenda

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HN Enrollment Summary - Medi-Cal

Health Network Name	FEBRUARY 2019	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	145,731	19.6%	22.6%
Monarch Family HealthCare (HMO16)	79,533	10.7%	12.3%
CalOptima Community Network (CN)	76,050	10.2%	11.8%
Arta Western Health Network (SRG66)	63,161	8.5%	9.8%
Alta Med Health Services (SRG69)	47,711	6.4%	7.4%
Family Choice Health Network (PHC21)	45,689	6.1%	7.1%
Kaiser Permanente (HMO04)	44,863	6.0%	6.9%
Prospect Medical Group (HMO17)	34,233	4.6%	5.3%
United Care Medical Network (SRG67)	33,270	4.5%	5.2%
Talbert Medical Group (SRG65)	24,225	3.3%	3.8%
Noble Mid-Orange County (SRG64)	22,829	3.1%	3.5%
AMVI Care Health Network (PHC58)	22,028	3.0%	3.4%
Heritage - Regal Medical Group (HMO15)	6,387	0.9%	1.0%
Total Health Network Capitated Enrollment	**645,711**	**86.9%**	**100.0%**
CalOptima Direct (all others)	97,489	13.1%	
Total Medi-Cal Enrollment	**743,200**	**100.0%**	

Back to Agenda

HN Enrollment Summary – OneCare Connect

Health Network Name	FEBRUARY 2019	Percentage
Monarch HealthCare (HMO16DB)	4,649	32.8%
Prospect Medical Group (HMO17DB)	2,410	17.0%
Family Choice Medical Group (SRG81DB)	1,761	12.4%
CalOptima Community Network (CN)	1,659	11.7%
Talbert Medical Group (SRG52DB)	1,042	7.4%
Arta Western Health Network(SRG66DB)	566	4.0%
Alta-Med (SRG69DB)	539	3.8%
United Care Medical Group (SRG67DB)	504	3.6%
Noble Mid Orange County (SRG64DB)	428	3.0%
AMVI Care Health Network (PHC58DB)	415	2.9%
Heritage - Regal Medical Group (HMO15)	192	1.4%
Total OneCare Connect Enrollment	**14,165**	**100.0%**

Back to Agenda

HN Enrollment Summary - OneCare

Health Network Name	FEBRUARY 2019	Percentage
Monarch HealthCare (PMG53DE)	695	46.9%
AMVI/Prospect Medical Group (PMG27DE)	281	19.0%
Talbert Medical Group (PMG52DE)	144	9.7%
Arta Western Health Network (PMG66DE)	108	7.3%
Family Choice Medical Group (PMG21DE)	90	6.1%
Alta-Med (PMG69DE)	84	5.7%
United Care Medical Group (PMG67DE)	47	3.2%
Noble Mid Orange County (PMG64DE)	33	2.2%
Total OneCare Enrollment	**1,482**	**100.0%**

Back to Agenda

Health Networks Quality Ranking Proposal

Provider Advisory Committee
March 14, 2019

Kelly Rex-Kimmet
Director, Quality Analytics

Back to Agenda

Why?

- To consider a new quality measure set for auto assignment and possibly P4V 2020
- Current measures are outdated and internally developed vs. use of an industry standard measure set and method.
- Measures must be reviewed annually.
- There are currently three different sets of quality measures for auto assignment and a different set of measure for Pay For Value.

Back to Agenda

Proposed Measure List

- Same list of measures for NCQA Health Plan Rating proposed:
  - Total 44 measures for Medicaid population including:
    - 11 Prevention measures
    - 25 Treatment measures
    - 8 Satisfaction measures
    - See NCQA Health Plan Rating Methodology Attachment for list of measures
- Measures excluded
  - 4 measures have no benefits (NB) — ADV, APP, FUH, IET
  - 5 measures have no data (NA) for more than half of health networks: ADD, APM, SAA, SSD, MSC (Advising Smokers to Quit from CAHPS)
  - Modeled results used measurement year 2017 audited HEDIS results and health network level adult/child CAHPS (whichever is higher)

Calculation

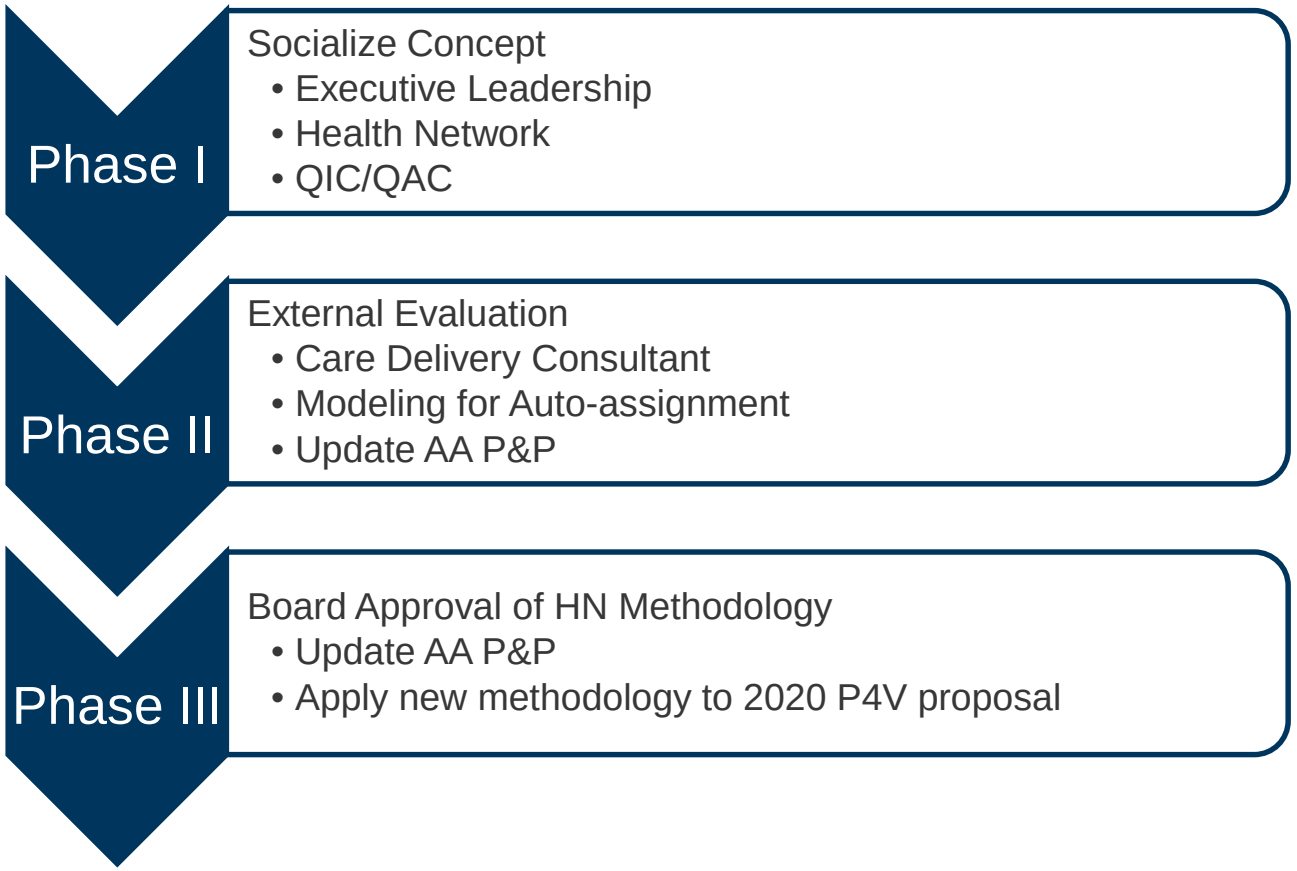
- Measure Weights:
  - Screening measures = weight of 1
  - Outcome measures = weight of 3
  - Member Experience = weight of 1
- NCQA Quality Compass Medicaid national percentiles are used as benchmarks.
- Score points
  - 5 — Top decile (>=90th percentile)
  - 4 — Top 3rd but not in the top 10th (>=66th but <90th percentile)
  - 3 — middle 3rd (>=33rd but <66th percentile)
  - 2 — bottom 3rd (>=10th but <33rd percentile)
  - 1 — bottom 10th percentile (<10th percentile)

Modeling of Health Network Ranking/Rating (HEDIS + CAHPS + Accreditation Bonus)

Ranking HEDIS + CAHPS + Accreditation Bonus						
Health Network	**# of Measures**	**Total Points**	**Total Weight**	**Score**	**Ranking**	**Rating**
UNITED CARE MEDICAL GROUP	35	195.9	49	4.00	1	**4.0**
ALTAMED HEALTH SERVICES	33	180.4	46	3.92	2	**4.0**
CalOptima	**35**	**189.4**	**49**	**3.87**		**4.0**
ARTA WESTERN HEALTH NETWORK	35	178.9	49	3.65	3	**3.5**
TALBERT MEDICAL GROUP	35	177.4	49	3.62	4	**3.5**
FAMILY CHOICE HEALTH NETWORK	35	175.4	49	3.58	5	**3.5**
MONARCH FAMILY HEALTHCARE	35	173.9	49	3.55	6	**3.5**
CCN	35	172.4	49	3.52	7	**3.5**
PROSPECT MEDICAL GROUP, INC.	35	171.9	49	3.51	8	**3.5**
CHOC HEALTH ALLIANCE	25	128.5	38	3.38	9	**3.5**
NOBLE MID-ORANGE COUNTY	31	147.0	44	3.34	10	**3.5**
AMVI CARE HEALTH NETWORK	32	153.4	46	3.34	11	**3.5**
HERITAGE - REGAL MEDICAL GROUP	23	97.5	33	2.95	12	**3.0**

Results based on calendar year 2017 performance.

Next Steps



Back to Agenda

CalOptima's Mission

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

Back to Agenda

Back to Agenda

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NCQA Health Insurance Plan Ratings Methodology
July 2018

REVISION CHART

Date Published	Description
March 23, 2018	*Updated measure list to remove Medicare EDU.*
June 28, 2018	*Removed the customer service measure from the commercial product line due to insufficient data and clarified the thresholds and scoring for emergency department utilization.*
July 24, 2018	*Added section 6.3: 1876 Cost Plans.*

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

1. Terminology and timing

1.1.1 Ratings vs. rankings

The 2018–2019 Health Insurance Plan Ratings are scheduled to be publicly released in September 2018.

2. Summary

Health plans are rated in three categories: private plans in which people enroll through work or on their own; plans that serve Medicare[1] beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries. This year's ratings do not include Marketplace plans because they have not developed sufficient data for analysis.

NCQA ratings are based on three types of quality measures: measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®[2]); measures of consumer satisfaction using Consumer Assessment of Healthcare Providers and Systems (CAHPS®[3]); and results from NCQA's review of a health plan's health quality processes (performance on NCQA Accreditation standards). NCQA rates health plans that report quality information publicly.

Ratings contact information

NCQA's Health Insurance Plan Ratings Help Desk: https://my.ncqa.org/.

3. How are plans rated?

3.1.1 Overall rating

The overall rating is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus accreditation standards (if the plan is accredited by NCQA), rounded to the nearest half point. Accreditation standards are given 10 percent of the weight of the valid HEDIS and CAHPS measures that a plan submits.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points. Performance includes three subcategories (also scored 0–5 in half points):

1. **Consumer Satisfaction:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Consumer Satisfaction category).
2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. **NCQA Accreditation Standards Score:** Partial and proportionally adjusted results of NCQA Accreditation surveys (actual NCQA Accreditation standards score divided by the maximum possible NCQA Accreditation standards score).

Refer to *Section 9.2: Measure Lists*.

[1]Medicare ratings on approval from CMS.
[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

3.1.2 Measures included

All publicly reportable clinical and consumer satisfaction measures are eligible for inclusion. Selected measures have good differentiating properties, up-to-date evidence and high population impact. After data are received, NCQA removes measures that violate the 40% Rule, which states that if less than 40 percent of responses contain scorable rates (non NA or NB), the measure is removed from the HPR methodology.

Note: *At NCQA's discretion, there may be exceptions to measures included in the 40% Rule scorable measure calculation.*

Refer to Section 9 for a full list of measures and indicators.

3.1.3 Handling missing values

Measures that are not reported (NR), not required (NQ) or have biased rates (BR) are given a rating of "0."

Measures with missing values because of small denominators (NA) or because the plan did not offer the benefit (NB) are not used in the plan's composite or overall rating. A plan must have scorable rates (a valid performance rate, NR, NQ, BR) for at least half of all measures by weight to receive an overall rating.

3.1.4 Measure weights

- Process measures (such as screenings) are given a weight of 1.
- Outcome and intermediate outcome measures (e.g., HbA1c or blood pressure control and childhood immunizations) are given a weight of 3.
- Patient experience measures are given a weight of 1.5.
- Accreditation standards are weighted at 10 percent of the total weight of a plan's valid HEDIS and CAHPS measures.

3.1.5 Calculating performance on NCQA Accreditation standards

NCQA evaluates health plan policies and processes for supporting quality improvement through accreditation to produce the "standards score" (the plan's score on the Accreditation standards) component. Because rating calculations include HEDIS results, NCQA uses only the standards score in the ratings—applying HEDIS results would be redundant. If a plan has an NCQA status modifier (e.g., Under Review by NCQA) as of June 30, it will be appended to the Accreditation status.

The standards score is calculated using data as of June 30:

Figure 1. NCQA Accreditation Standards Scoring for Rated and Partial Data Plans

Accreditation Achieved	Accreditation Standards Score	Points in Ratings Score for Accreditation	Ratings Display
Health Plan	Actual points / possible points	(Actual points / possible points) * 5 * 10% of the weight of valid reported measures	NCQA Accreditation = Yes
Interim	Actual points / possible points	(Actual points / possible points) * 5 * (1/3) * 10% of the weight of valid reported measures	NCQA Accreditation = Yes—Interim
In Process	No final standards score	0.0000	NCQA Accreditation = No (In process)
Scheduled	No final standards score	0.0000	NCQA Accreditation = No (Scheduled)
None	None	0.0000	NCQA Accreditation = No

4. Final plan rating

NCQA displays rating results by plan name in alphabetical order, from 0–5 in increments of 0.5.

4.1 *Measure and Composite ratings*

4.1.1 Composites and subcomposites

NCQA combines and sorts measures into categories according to conceptually related services. Ratings are displayed at the composite, subcomposite and individual measure level.

A composite or subcomposite rating is the weighted average of a plan's HEDIS and CAHPS measure ratings in those categories. The weight of any NR, NQ, and BR measure is included. NCQA uses the following formula to score composites and subcomposites:

$$\text{(Sub) Composite Rating} = \sum (\text{measure rating} * \text{measure weight}) / \sum \text{weights}$$

4.1.2 Deriving ratings from individual results and national benchmarks

The National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure percentiles are used for ratings, calculated as whole numbers on a 1–5 scale.

	Rating
A plan that is in the top decile of plans	**5**
A plan that is in the top 3rd of plans, but not in the top 10th	**4**
A plan in the middle 3rd of all plans	**3**
A plan that is in the bottom 3rd of plans, but not in the bottom 10 percent	**2**
A plan that is in the bottom 10 percent of plans	**1**

4.1.3 Scoring *Plan All-Cause Readmissions* and *Emergency Department Utilization*

Plan All-Cause Readmissions (PCR) and *Emergency Department Utilization (EDU)* are case-mix adjusted measures. EDU is new to HPR 2018. The traditional scoring model was modified: PCR is reported as a ratio of observed to expected (O/E) hospital readmissions; EDU is reported as O/E emergency department visits.

To identify meaningful distinctions between plans, NCQA distinguishes between three levels of performance using statistical significance testing: better-than-expected, lower-than-expected, same-as-expected. Before evaluating the plan's O/E thresholds as outlined below, the ratio is divided by the national average O/E ratio to determine its percentage above or below the national average. This calibrated value is then compared to 1.0 for scoring.

- *A calibrated O/E ratio >1.0*: The plan had a below-average O/E ratio, based on its case mix.
- *A calibrated O/E ratio <1.0*: The plan had an above-average O/E ratio, based on its case mix.

Plans with fewer than 150 denominator events (Count of Index Stays for PCR, Total Number of Members in Eligible Population for EDU) are scored NA. To help protect against trivial (but statistically significant) differences, we use an effect size threshold of 0.9 and 1.1.

Calibrated O/Es must be significantly different from 1.0 and exceed the upper and lower confidence intervals; therefore, these measures use a 3-point scale to determine low, medium and high levels of performance that we have mapped to HPR's 5-point scale.

To calculate the calibrated Upper and Lower Confidence Intervals use the following:

- *Lower Confidence Interval*: (((Observed Count –(1.96*sqrt(variance))))⁄(Expected Count) / Mean O/E)
- *Upper Confidence Interval*: (((Observed Count+(1.96*sqrt(variance))))⁄(Expected Count) / Mean O/E)

The following table outlines the three-level grouping and points earned for each group:

PCR and EDU Scoring Rule	HPR Scoring
Calibrated O/E <0.9 and calibrated upper confidence interval <1.0	5
Calibrated O/E not meaningfully and significantly different from 1.0 (0.9 ≤ O/E ≤ 1.1 or calibrated confidence intervals include 1.0)	3
Calibrated O/E >1.1 and calibrated lower confidence interval >1.0	1
O/E has a NR, BR, or NQ HEDIS®[4] audit result	0
Plan's denominator/eligible population <150 or plan has a missing variance or a variance equal to zero	NA

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

5. How are plans displayed?

5.1 *What plans are rated or receive scores?*

Plans with complete data (both HEDIS and CAHPS) that have elected to publicly report data are rated; plans with partial or no data, or that do not publicly report, are listed but not rated.

5.2 *Plans with partial data*

Plans with partial data do not receive a rating, but NCQA lists them in the ratings and shows their scores on the measures they report. A plan is considered to have partial data if it:

- Submits HEDIS and CAHPS measure data for public reporting, but has "missing values" (i.e., NA or NB) in more than 50 percent of the weight of measures used in the methodology. Plans that fall into this category receive an overall rating status of "Partial Data Reported" and their measure rates are displayed as "NC" (No Credit). Refer to *HEDIS Volume 2: Technical Specifications* for information about missing values.
- Submits HEDIS data for public reporting but does not submit CAHPS data, or vice versa. Plans that fall into this category receive an overall rating status of "Partial Data Reported" and their measure rates for the dataset they did not submit are displayed as "NC" (No Credit).
- Earned NCQA Accreditation without HEDIS data (health plan accreditation standards only) and did not submit HEDIS or CAHPS data for public reporting. Plans that fall into this category receive an overall rating status of "Partial Data Reported" and their measure rates are displayed as "NC" (No Credit).

5.2.1 No data reported

Plans that submit results but do not report data publicly, or plans that report no HEDIS, CAHPS or accreditation information to NCQA, are given a rating status of "No Data Reported" and their measure rates are displayed as "NC" (No Credit). Plans that fall into this category and have fewer than 8,000 members are omitted—they are not rated and are not listed in displays related to ratings.

6. Additional rules

6.1 *Medicaid CAHPS and benchmarks*

Medicaid plans may choose the version of the CAHPS survey (or "component") they want scored: Adult CAHPS, Child CAHPS or Child With Chronic Conditions CAHPS (Child CCC).[5]

Plans designate the CAHPS component when completing the 2018 Healthcare Organization Questionnaire (HOQ). Designations may not be changed and are benchmarked by component selected:

- Adult CAHPS benchmarks are based on adult rates only.
- Child and Child CCC CAHPS benchmarks are based on the combined general population rates for both components.

[5]CAHPS components are described in more detail in *HEDIS Volume 3: Specifications for Survey Measures.*

6.2 *Medicare CAHPS and Health Outcome Survey*

Using Medicare CAHPS and Health Outcome Survey (HOS) data in the ratings depends on yearly approval from the Centers for Medicare & Medicaid Services (CMS). Because the submission schedule for Medicare CAHPS and HOS measures differs from the HEDIS submission schedule, NCQA uses the previous year's data for measures in the CAHPS and HOS domain in the Medicare product line. For Medicare plans that were not required to submit CAHPS or HOS in the previous year, these measures are displayed as "NC" (No Credit).

6.3 *1876 Cost Plans*

As of 2017, CMS no longer allows 1876 Cost Plans to submit data on measures that require inpatient data; therefore, submit "NQ" for these measures. "NQ" will be treated the same as "NA" and "NB," and will not count against a Medicare plan's NA limit.

6.4 *Other Display Scenarios*

To simplify the ratings display logic, NCQA developed the following display rules:

Apply First	
Rate/Scenario	**Display**
Plan submits NR (Not Reported) for a measure indicator	NC (No Credit)
Plan submits BR (Biased Rate) for a measure indicator	NC (No Credit)
Plan submits NQ (Not Required) for a measure indicator	NC (No Credit)
Plan submits NA (Not Applicable) for a measure indicator	NA (Not Applicable)
Plan submits NB (No Benefit) for a measure indicator	NA (Not Applicable)
For Medicare, if "CAHPS Submitted = False" and "CAHPS Required = True"	Display as NC, overall Rating=Partial Data Reported
For Medicare, if "CAHPS Submitted = False" and "CAHPS Required = FALSE"	Display as NA, overall Rating=Partial Data Reported

Apply Second	
Rate/Scenario	**Display**
Plan is Accredited on HEDIS/CAHPS and did not elect to public report results on the IDSS Attestation. These plans will be rated assuming they submitted scorable data for more than 50% of measure weights.	*Plans that are NCQA Accredited with HEDIS and marked their submission "Not Publicly Reported"* on the Attestation are eligible for ratings. All measures are used to calculate the overall rating, but only scores for measures required for accreditation are displayed. Measures not required for accreditation are displayed as "Not Public [NP]."
Plan is Accredited on Standards only but submits HEDIS/CAHPS and did not elect to public report results on the IDSS Attestation. Plans will have an overall rating score of Partial Data Reported.	NC (No Credit) for all measures

Apply Second	
Rate/Scenario	**Display**
Plan is Accredited on Standards only and did not submit any data or submitted either HEDIS or CAHPS only. Plans will have an overall rating score of Partial Data Reported.	NC (No Credit) for all measures the plan did not submit, except Medicare, which should follow the Medicare CAHPS rules above.
Plan is not Accredited and submitted either HEDIS or CAHPS only and said Yes to public reporting on the IDSS Attestation. Plans will have an overall rating score of Partial Data Reported.	NC (No Credit) for all measures the plan did not submit, except for Medicare, which should follow the Medicare CAHPS rules above.
Plan is not Accredited and did not submit any data.	NC (No Credit) for all measures
Plan is not Accredited and submitted data but did not elect to public report results on the IDSS Attestation. Plans will have an overall rating score of No Data Reported.	NC (No Credit) for all measures

7. Special Needs Plans

Special Needs Plans (SNP) with all members categorized as “special needs members” according to CMS, are flagged in the rating displays.

8. Schedule

Find the 2018 ratings schedule here.

9. Appendix

9.1 *Definition of health insurance plans*

A “health insurance plan” is a type of coverage that pays for medical and surgical expenses incurred by its insured members. Health insurance plans, including health maintenance organizations (HMO), point of service (POS) organizations and preferred provider organizations (PPO) with coverage in the 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands, are included in the final ratings.

9.2 *Measure lists*

The following lists include all measures included in NCQA's Health Insurance Plan Ratings for the 2018–2019 methodology for each product line. This list is subject to change at any time.

The **Weight** column indicates the weight of the item (maximum value = 3) in the overall score calculation.

Private/Commercial

Measure Name		Web Display Name	Weight
CONSUMER SATISFACTION			
Getting care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary-care doctor	1.5
Rating of Specialist Seen Most Often (9 + 10)		Rating of specialists	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
Coordination of Care (Usually + Always)		Coordination of care	1.5
Satisfaction With Plan Services			
Claims Processing (Usually + Always)		Handling claims	1.5
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
PREVENTION			
Children and Adolescent Well-Care			
CIS	Childhood Immunization Status—Combo 10	Childhood immunizations status-combination 10	3
IMA	Immunizations for Adolescents—Combo 2	Adolescent immunizations: Combo 2	3
WCC	Weight Assessment and Counseling—BMI Percentile—Total	BMI percentile assessment	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1

Measure Name		Web Display Name	Weight
Cancer Screening			
BCS	Breast Cancer Screening	Breast cancer screening	1
COL	Colorectal Cancer Screening	Colorectal cancer screening	1
CCS	Cervical Cancer Screening	Cervical cancer screening	1
Other Preventive Services			
ABA	Adult BMI Assessment	Adult BMI assessment	1
CHL	Chlamydia Screening in Women—Total	Chlamydia screening	1
FVA	Flu Vaccinations for Adults Ages 18-64	Flu shots for adults	1
TREATMENT			
Asthma			
AMR	Asthma Medication Ratio—Total	Asthma control	1
MMA	Medication Management for People With Asthma: Medication Compliance 75% –Total	Asthma drug management	1
TREATMENT			
Diabetes			
CDC	Comprehensive Diabetes Care—Eye Exams	Eye exams	1
	Comprehensive Diabetes Care—Blood Pressure Control (<140/90)	Blood pressure control (140/90)	3
	Comprehensive Diabetes Care—HbA1c Control (<8%)	Glucose control	3
SPD	Statin Therapy for Patients With Diabetes Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure—Total	Controlling high blood pressure	3

Measure Name		Web Display Name	Weight
Mental and Behavioral Health			
ADD	Follow Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	Continued follow-up after ADHD diagnosis	1
AMM	Antidepressant Medication Management—Continuation Phase	Depression: Adhering to medication for 6 months	1
FUH	Follow Up After Hospitalization For Mental Illness—7 days	Follow-up after hospitalization for mental illness	1
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment—Engagement of AOD—Total	Alcohol or drug abuse or dependence treatment engaged	1
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
TREATMENT			
Other Treatment Measures			
PCR	Plan All-Cause Readmissions—Observed-To-Expected Ratio	Observed-to-expected hospital readmissions	3
EDU	Emergency Department Utilization—Observed-To-Expected Ratio—Total	Emergency department utilization	1
AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Appropriate antibiotic use, adults with acute bronchitis	1
CWP	Appropriate Testing for Children With Pharyngitis	Appropriate testing and care, children with sore throat	1
LBP	Use of Imaging Studies for Low Back Pain	Appropriate use of imaging studies for low back pain	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
URI	Appropriate Treatment for Children With Upper Respiratory Infection	Appropriate antibiotic use, children with colds	1

Medicare

Measure Name		Web Display Name	Weight
CONSUMER SATISFACTION			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary-care doctor	1.5
Rating of Specialist (9 + 10)		Rating of specialists	1.5
Rating of Your Health Care (9 + 10)		Rating of care	1.5
Coordination of Care (Usually + Always)		Coordination of care	1.5
Satisfaction With Plan Services			
Rating of Your Health Plan (9 + 10)		Rating of health plan	1.5
PREVENTION			
BCS	Breast Cancer Screening	Breast cancer screening	1
COL	Colorectal Cancer Screening	Colorectal cancer screening	1
FVO	Flu Vaccinations for Adults Ages 65 and Older	Flu shots	1
PNU	Pneumococcal Vaccination Status for Older Adults	Pneumonia shots	1
TREATMENT			
Diabetes			
CDC	Comprehensive Diabetes Care—Blood Pressure Control (<140/90)	Blood pressure control (140/90)	3
	Comprehensive Diabetes Care—Eye Exams	Eye exams	1
	Comprehensive Diabetes Care—HbA1c Control (<8%)	Glucose control	3
SPD	Statin Therapy for Patients With Diabetes Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1

	Measure Name	Web Display Name	Weight
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure—Total	Controlling high blood pressure	3
MSC	Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	Smoking advice	1
Mental and Behavioral Health			
AMM	Antidepressant Medication Management—Continuation Phase	Depression: Adhering to medication for 6 months	1
FUH	Follow Up After Hospitalization For Mental Illness—7 days	Follow-up after hospitalization for mental illness	1
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment—Engagement of Treatment	Alcohol or drug abuse or dependence treatment engaged	1
Other Treatment Measures			
PCR	Plan All-Cause Readmissions—Observed-To-Expected Ratio (65+)	Observed-to-expected hospital readmissions	3
FRM	Managing Fall Risk	Managing risk of falls	1
PSA	Non-Recommended PSA-Based Screening in Older Men	Non-recommended prostate cancer screening in older men	1
DDE	Potentially Harmful Drug Disease Interactions in the Elderly—Total	Avoiding harmful drug and disease interactions	1
DAE	Use of High-Risk Medications in the Elderly—One Prescription	Avoiding high-risk medications	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
OTO	Osteoporosis Testing in Older Women	Testing for osteoporosis	1
OMW	Osteoporosis Management in Women Who Had a Fracture	Managing osteoporosis in women after fracture	1

Medicaid

Measure Name		Web Display Name	Weight
CONSUMER SATISFACTION			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary-care doctor	1.5
Rating of Specialist Seen Most Often (9+ 10)		Rating of specialists	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
Coordination of Care (Usually + Always)		Coordination of care	1.5
Satisfaction With Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Customer Service (Usually + Always)		Customer service	1.5
PREVENTION			
Children and Adolescent Well-Care			
ADV	Annual Dental Visits—Total	Dental visits	1
CIS	Childhood Immunization Status—Combo 10	Childhood immunizations status-combination 10	3
IMA	Immunizations for Adolescents—Combo 2	Adolescent immunizations: Combo 2	3
WCC	Weight Assessment—BMI Percentile—Total	BMI percentile assessment	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1

Measure Name		Web Display Name	Weight
Cancer Screening			
BCS	Breast Cancer Screening	Breast cancer screening	1
CCS	Cervical Cancer Screening	Cervical cancer screening	1
Other Preventive Services			
ABA	Adult BMI Assessment	Adult BMI assessment	1
CHL	Chlamydia Screening in Women—Total	Chlamydia screening	1
FVA	Flu Vaccinations for Adults Ages 18-64	Flu shots	1
TREATMENT			
Asthma			
AMR	Asthma Medication Ratio—Total	Asthma control	1
MMA	Medication Management for People With Asthma: Medication Compliance 75%—Total	Asthma drug management	1
Diabetes			
CDC	Comprehensive Diabetes Care—Eye Exams	Eye exams	1
	Comprehensive Diabetes Care—Blood Pressure Control (<140/90)	Blood pressure control (140/90)	3
	Comprehensive Diabetes Care—HbA1c Control (<8%)	Glucose control	3
SPD	Statin Therapy for Patients With Diabetes Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease Received Statin Therapy – Total	Patients with cardiovascular disease – received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80% – Total	Patients with cardiovascular disease – statin adherence 80%	1
CBP	Controlling High Blood Pressure – Total	Controlling high blood pressure	3
MSC	Medical Assistance With Smoking and Tobacco Use Cessation – Advising Smokers and Tobacco Users to Quit	Smoking advice	1

Mental and Behavioral Health			
AMM	Antidepressant Medication Management—Continuation Phase	Depression: Adhering to medication for 6 months	1
FUH	Follow Up After Hospitalization For Mental Illness—7 days	Follow-up after hospitalization for mental illness	1
IET	Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment—Engagement—Total	Alcohol or drug abuse or dependence treatment engaged	1
ADD	Follow Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Drugs	Schizophrenia: Diabetes screening for schizophrenia or bipolar	1
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
Other Treatment Measures			
AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Appropriate antibiotic use, adults with acute bronchitis	1
CWP	Appropriate Testing for Children With Pharyngitis	Appropriate testing and care, children with sore throat	1
LBP	Use of Imaging Studies for Low Back Pain	Appropriate use of imaging studies for low back pain	1
URI	Appropriate Treatment for Children With Upper Respiratory Infection	Appropriate antibiotic use, children with colds	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1