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

THURSDAY, APRIL 11, 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 March 14, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC)

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

V. REPORTS

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. Behavioral Health Update
B. Community Clinics Presentation
C. PAC Goals and Objectives
D. PAC Member Updates

VIII. COMMITTEE MEMBER COMMENTS

IX. ADJOURNMENT

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MINUTES

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

March 14, 2019

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

CALL TO ORDER

Teri Miranti, PAC Vice Chair, called the meeting to order at 8:09 am. Dr. Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Vice Chair; Anjan Batra, M.D; Donald Bruhns; Theodore Caliendo, M.D.; Stephen Flood; Jena Jensen; Junie Lazo-Pearson, Ph.D.; Craig Myers; Mary Pham, Pharm.D., CHC; Jacob Sweidan, M.D.
Members Absent:	John Nishimoto, O.D., Chair; Brian Lee, Ph.D.
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Arif Shaikh, Director, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Specialist, Customer Service

MINUTES

Approve the Minutes of the February 14, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Dr. Sweidan, seconded and carried, the Committee approved the minutes of the February 14, 2019 meeting. (Motion carried 10-0-0; Members Lee and Nishimoto absent)***

PUBLIC COMMENTS

There were no requests for public comment.

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REPORTS

Consider Recommendations of Provider Advisory Committee Hospital Representative Candidate

At the February 14, 2019 PAC meeting, a Nominations Ad Hoc Committee (Ad Hoc), comprised of Vice Chair Miranti and Members Myers and Sweidan, was formed to review and recommend a candidate for the open Hospital seat. The members of the Ad Hoc Committee met via conference call on March 6, 2019 to discuss and review the application received.

The Nominations Ad Hoc Committee recommended Harold Patton, RN. MSN, Chief Nursing Officer at the University of California Irvine Medical Center as a candidate for the open Hospital seat for a term expiring on June 30, 2020. The recommendation will be presented to the Board of Directors for consideration at their May 2, 2019 meeting.

Action: ***On motion of Dr. Sweidan, seconded and carried, the Committee recommended that the Board of Directors consider the appointment of Harold Patton, RN, MSN, as the Hospital Representative for a term expiring on June 30, 2020. (Motion carried 10-0-0; Members Lee and Nishimoto absent)***

After approval of the recommendation, Member Myers, suggested the formation of an Ad Hoc Committee to review the candidate application process prior to the next annual recruitment in 2020.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), provided an update to the Committee on the open nomination process for MAC and PAC. In addition, she provided an update on CalOptima's annual Qualified Medical Beneficiaries (QMB) project. She also noted that the Health Homes Program launch was deferred from July 1, 2019 to January 1, 2020 at the request of CalOptima.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), provided an update on CalOptima's approach to Clinical Quality metrics.

Vice Chair Miranti reordered the agenda to hear Item VII.C., Proposed Health Network Quality Performance Rating Methodology.

Proposed Health Network Quality Performance Rating Methodology Presentation

Kelly Rex-Kimmet, Director, Quality Analytics, provided a comprehensive presentation on CalOptima's Health Networks Quality Ranking Proposal and the next steps. A discussion among the members and management ensued regarding standards of excellence and the issue that not all

National Committee for Quality Assurance (NCQA) metrics align with Medi-Cal covered services. Ms. Rex-Kimmet advised the Committee that CalOptima continues to work with a consultant and the metrics will be shared with the health networks, Quality Improvement Committee (QIC) and Board prior to implementation.

Chief Financial Officer

Nancy Huang, Interim Chief Financial Officer, provided an update on the Department of Health Care Services (DHCS) 2017/18 rates for the Proposition 56, Supplemental Payments and noted that rates would be increasing for 2018/19. Ms. Huang noted that for July 1, 2019, the fee-for-service networks would be accountable for paying this rate increase. CalOptima will use the current reconciliation process upon receipt of the payment in March 2019. Ms. Huang advised the committee that the Centers for Medicare & Medicaid Services (CMS) would be auditing all plans on Medical Loss Ratio (MLR) covering the last 30 months.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, provided an update on the submission of signed contracts to DHCS for the Network Adequacy for CalOptima's health networks. Ms. Laughlin was pleased to report that CalOptima completed the filing, and the DHCS is currently reviewing the file and CalOptima is expected to hear back on March 15, 2019. Member Sweidan asked whether CalOptima could speak to DHCS about the possibility of carving out the new hemophilia drugs that are needed by some of the children transferring from California Children's Services (CCS) to the Whole-Child Model. After discussion among several PAC members, Dr. Ramirez agreed to investigate it and would provide an update to the committee.

Federal & State Budget Update

Arif Shaikh, Director, Government Affairs, provided an update on the Department of Managed Health Care (DMHC) new regulation on global risk. He noted that CalOptima is exempt from having to hold a Knox Keene license, but that there is a possibility that this new Knox Keene licensing requirements may impact some of CalOptima's health networks.

INFORMATION ITEMS

Homeless Health Update

Michael Schrader, Chief Executive Officer, a detailed summary CalOptima's Homeless Health Imitative and the steps that CalOptima will be taking to address them. He noted that CalOptima is working closely with Federally Qualified Health Centers (FQHCs) to support clinical field teams. CalOptima is also seeking legal opinions on the use of Intergovernmental Transfer (IGT) Funds for non-Medi-Cal services. He also mentioned there are two paths to support housing initiatives: 1) build housing and rent assistance. CalOptima is waiting for guidance from the DHCS on this initiative and 2) offer case management to help coordinate and refer homeless people to housing services.

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PAC Member Updates

Vice Chair Miranti announced that the PAC will continue their recruitment for the nurse position and noted that several applications have been received for this seat and will be reviewed in April with the 2019 annual recruitment applicants. Vice Chair Miranti announced the 2019 annual recruitment is under way and applications are being accepted for the following seats: Long-Term Services and Supports (2 seats), Non-Physician Medical Practitioner, Pharmacy, and Physician (2 seats) Representatives. She also noted that nominations for the Chair and Vice Chair positions were also being accepted.

Vice Chair Miranti formed a 2019 Nominations Ad Hoc committee to review applications and make recommendations. Members Myers, Pham and Sweidan agreed to serve on the ad hoc.

ADJOURNMENT

There being no further business, Vice Chair Miranti adjourned the meeting at 10:04 a.m.

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

Approved: April 11, 2019

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MEMORANDUM

DATE:	April 4, 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) Networks Meet Certification Standards for July Launch
On March 15, the Department of Health Care Services (DHCS) certified that CalOptima's 12 delegated health networks and our direct network, CalOptima Community Network, meet the requirements for WCM participation. Therefore, the transition of California Children's Services to WCM in Orange County is officially approved for July 1, 2019. Thank you to our health networks for their partnership in this effort to provide access to more coordinated care for children with medically complex conditions. We look forward to a successful launch. Further, CalOptima continues to engage with stakeholder groups at the local and state levels to ensure awareness and work toward a smooth transition. Our WCM Family Advisory Committee is meeting bimonthly and offering valuable feedback to staff, and CalOptima was asked to make a presentation to the California Children's Services Advisory Group this month in Sacramento. Chief Medical Officer David Ramirez, M.D., will be sharing the information about our delegated model, members' access to out-of-network care, the role of CalOptima Direct and CalOptima Community Network, and auto-assignment processes.

Ad Hoc on Homeless Health to Recommend Major Commitment to Additional Programs
CalOptima's focus on Orange County's homeless health crisis is evident in actions the past few months. Not only was there a special meeting for the full Board in February resulting in approval of our clinical field teams and CalOptima Homeless Response Team, a newly appointed ad hoc committee amplified their work in March, issuing a set of recommendations for significant financial support to homeless health initiatives. Your April Board materials include a presentation and two report items that collectively reflect CalOptima's commitment to partnering with Orange County and community organizations to make a difference in the lives of CalOptima members who are homeless.

Audit Finds Medi-Cal Services for Children Lacking; Regulators and Legislators Respond
On March 14, the California State Auditor issued a report about DHCS oversight of preventive care for children in Medi-Cal. The report cites deficiencies in utilization of preventive care, based in part on provider access issues due to low reimbursement. Fortunately, CalOptima is included somewhat favorably in the report. While all plans can do more to ensure delivery of preventive care for children, CalOptima's 60.7 percent utilization rate is second only to San Francisco Health Plan's 64.2 percent. The lowest rate among the 23 plans listed was 39.9 percent. As a result of the audit's largely negative findings, DHCS announced a series of stricter

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quality oversight measures, including new performance benchmarks and sanctions for noncompliance. Further, Assemblyman Jim Wood also introduced legislation to implement similar controls. We are carefully monitoring this regulatory and legislative activity to ensure that CalOptima continues to serve our youngest members according to high quality standards.

Governor Introduces Individual Mandate as Part of Budget Trailer Bill
Reflecting his focus on California health care issues, Gov. Gavin Newsom introduced a state-based requirement to obtain health care coverage, known as an individual mandate, with the release of FY 2019–20 budget trailer bill language in mid-March. The language includes a tax penalty of $695 per adult and $348 per child that would be collected by the state and deposited into the General Fund. The money would then be used to provide subsidies for coverage purchased through Covered California and expand subsidies to people between 400 percent to 600 percent of the federal poverty level. Experts predict that an individual mandate may also have the effect of driving more enrollment into Medi-Cal as eligible individuals seek coverage rather than pay penalties.

State Requests Pharmacy Data to Gauge Impact of Governor's Carve-Out Order
Gov. Newsom's executive order to carve out pharmacy services from Medi-Cal managed care took another step forward this past month. On March 26, CalOptima participated in a statewide call with DHCS, which has now requested data on pharmacy costs and utilization for our Medi-Cal and OneCare Connect programs. Officials are working to get a sense of the size of transition driven by the governor's order. Our industry associations continue to prioritize work on this issue by suggesting alternatives that may offer the desired result of lower overall drug costs without jeopardizing the care coordination inherent in managed care.

Cal MediConnect Poised for a Three-Year Extension That Brings Program Changes
The Cal MediConnect (CMC) program, including CalOptima OneCare Connect, is awaiting state and federal approval of a three-year extension that would authorize CMC through 2023 and introduce key changes. The extension includes new rules for financial penalties based on high rates of disenrollment starting in 2019, an increase in the quality withhold of 4 percent starting in 2020, and an experience rebate that would require plans to share with DHCS and the Centers for Medicare & Medicaid (CMS) any profit over a threshold. The California Association of Health Plans provided feedback in response to a DHCS request, suggesting certain enhancements, including passive enrollment of newly Medicare-eligible and a pilot to integrate In-Home Supportive Services, which was a component of the original CMC program. I will keep your Board apprised of CMC status as the extension will add further stability to OneCare Connect.

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Financial Summary

February 2019

Nancy Huang

Interim Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- February 2019 MTD:
  - Ø Overall enrollment was 761,202 member months
    - § Actual lower than budget 22,259 or 2.8%
      - Medi-Cal: unfavorable variance of 21,752 members
        - Ø Whole Child Model (WCM) unfavorable variance of 12,502 members
          - Actual members reside in their original aid codes until program starts
        - Ø Medi-Cal Expansion (MCE) unfavorable variance of 6,562 members
        - Ø Temporary Assistance for Needy Families (TANF) unfavorable variance of 4,586 members
        - Ø Long-Term Care (LTC) unfavorable variance of 146 members
        - Ø Seniors and Persons with Disabilities (SPD) favorable variance of 2,043 members
      - OneCare Connect: unfavorable variance of 644 members
    - § 2,704 decrease from January
      - Medi-Cal: decrease of 2,649
      - OneCare Connect: decrease of 78
      - OneCare: increase of 19
      - PACE: increase of 4

FY 2018-19: Consolidated Enrollment (cont.)

- February 2019 YTD:
  - Ø Overall enrollment was 6,162,179 member months
    - § Actual lower than budget 112,244 members or 1.8%
      - Medi-Cal: unfavorable variance of 110,227 members or 1.8%
        - Ø TANF unfavorable variance of 44,925 members
        - Ø MCE unfavorable variance of 41,031 members
        - Ø WCM unfavorable variance of 25,004 members
        - Ø LTC unfavorable variance of 650 members
        - Ø SPD favorable variance of 1,383 members
      - OneCare Connect: unfavorable variance of 2,749 members or 2.3%
      - OneCare: favorable variance of 744 members or 7.0%
      - PACE: unfavorable variance of 12 member or 0.5%

FY 2018-19: Consolidated Revenues

- February 2019 MTD:
  - Ø Actual lower than budget $11.0 million or 3.7%
    - § Medi-Cal: unfavorable to budget $10.1 million or 3.8%
      - Unfavorable volume variance of $7.6 million
      - Unfavorable price variance of $2.5 million
        - Ø $22.9 million of WCM revenue due to delayed start of program, offset by
        - Ø $13.8 million of Coordinated Care Initiative (CCI) revenue due to calendar year (CY) 2018 rate increase
        - Ø $9.8 million prior year (PY) CCI revenue due to CY 2018 true-up rate increase
        - Ø $1.4 million due to favorable MCE rates
    - § OneCare Connect: unfavorable to budget $1.4 million or 5.3%
      - Unfavorable volume variance of $1.2 million
      - Unfavorable price variance of $0.3 million
        - Ø Medicare Part C rates, offset by
        - Ø $1.7 million revenue true-up due to CY 2018 rate increase

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FY 2018-19: Consolidated Revenues (cont.)

- February 2019 MTD
  - § OneCare: favorable to budget $0.5 million or 28.8%
    - Favorable volume variance of $0.2 million
    - Favorable price variance of $0.3 million
  - § PACE: favorable to budget $0.1 million or 4.3%
    - Unfavorable volume variance of $0.1 million
    - Favorable price variance of $0.2 million

FY 2018-19: Consolidated Revenues (cont.)

- February 2019 YTD:
  - Ø Actual lower than budget $52.3 million or 2.3%
    - § Medi-Cal: unfavorable to budget $49.0 million or 2.4%
      - Unfavorable volume variance of $36.4 million
      - Unfavorable price variance of $12.6 million due to:
        - Ø $45.8 million of WCM revenue
        - Ø $10.6 million of FY19 non-LTC revenue from non-LTC aid codes
        - Ø $5.6 million of Proposition 56 revenue
        - Ø $2.0 million of FY19 Behavioral Health Treatment (BHT) revenue
        - Ø Offset by favorable variance due to:
          - $18.3 million of CCI revenue
          - $11.2 million due to favorable MCE rates
          - $3.1 million of Hepatitis C revenue
          - $4.5 million of PY non-LTC revenue from non-LTC aid codes
          - $11.3 million of PY CCI revenue

FY 2018-19: Consolidated Revenues (cont.)

- February 2019 YTD:

ØOneCare Connect: unfavorable to budget $3.5 million or 1.7%

- § Unfavorable volume variance of $4.7 million
- § Favorable price variance of $1.2 million

ØOneCare: favorable to budget $34.1 thousand or 0.3%

- § Favorable volume variance of $900.9 thousand
- § Unfavorable price variance of $866.9 thousand due to:

ØPACE: favorable to budget $137.6 thousand or 0.8%

- § Unfavorable volume variance of $87.1 thousand
- § Favorable price variance of $224.7 thousand

FY 2018-19: Consolidated Medical Expenses

- February 2019 MTD:
  - Ø Actual lower than budget $19.2 million or 7.0%
    - § Medi-Cal: favorable variance of $17.5 million
      - Favorable volume variance of $7.0 million
      - Favorable price variance of $10.5 million
        - Ø Provider Capitation expenses favorable variance of $6.3 million due to delay of WCM program, offset by Proposition 56 and Child Health and Disability Prevention Program (CHDP) expenses that were budgeted in Professional Claims
        - Ø Prescription Drug expenses favorable variance of $5.2 million mainly due to delay of WCM program
        - Ø Facilities expenses unfavorable variance of $4.5 million
        - Ø Professional Claim expenses favorable variance of $3.9 million due to:
          - CHDP expenses of $2.0 million
          - BHT expenses of $1.9 million
          - Proposition 56 expenses of $2.6 million offset by: Non-Medical Transportation (NMT) expenses of $0.3 million and Incurred But Not Reported (IBNR) expenses of $1.7 million

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

- February 2019 MTD:
  - ØOneCare Connect: favorable variance of $1.6 million or 6.6%
    - § Favorable volume variance of $1.1 million
    - § Favorable price variance of $0.5 million
  - ØOneCare: unfavorable variance of $194.2 thousand or 13.2%
    - § Unfavorable volume variance of $164.6 thousand
    - § Unfavorable price variance of $29.6 thousand
  - ØPACE: favorable variance of $0.3 million or 14.4%
    - § Favorable volume variance of $0.1 million
    - § Favorable price variance of $0.2 million

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

- February 2019 YTD:
  - Ø Actual lower than budget $85.2 million or 4.0%
    - § Medi-Cal: favorable variance of $81.4 million
      - Favorable volume variance of $34.5 million
      - Favorable price variance of $46.9 million
        - Ø Professional Claim expenses favorable variance of $46.4 million
        - Ø Prescription Drug expenses favorable variance of $22.2 million
        - Ø Facilities expenses unfavorable variance of $18.3 million
        - Ø Provider Capitation expenses unfavorable variance of $11.6 million
        - Ø Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $7.0 million
    - § OneCare Connect: favorable variance of $2.3 million
      - Favorable volume variance of $4.5 million
      - Unfavorable price variance of $2.2 million
- Medical Loss Ratio (MLR):
  - Ø February 2019 MTD: Actual: 88.7% Budget: 91.8%
  - Ø February 2019 YTD: Actual: 93.3% Budget: 94.9%

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FY 2018-19: Consolidated Administrative Expenses

- February 2019 MTD:
  - Ø Actual lower than budget $1.7 million or 13.4%
    - § Salaries, wages and benefits: favorable variance of $1.1 million
    - § Other categories: favorable variance of $0.5 million

- February 2019 YTD:
  - Ø Actual lower than budget $17.2 million or 17.0%
    - § Salaries, wages & benefits: favorable variance of $8.9 million
    - § Other categories: favorable variance of $8.3 million

- Administrative Loss Ratio (ALR):
  - Ø February 2019 MTD: Actual: 3.7% Budget: 4.1%
  - Ø February 2019 YTD: Actual: 3.8% Budget: 4.5%

FY 2018-19: Change in Net Assets

- February 2019 MTD:
  - Ø $25.4 million surplus
  - Ø $12.8 million favorable to budget
    - § Lower than budgeted revenue of $11.0 million
    - § Lower than budgeted medical expenses of $19.2 million
    - § Lower than budgeted administrative expenses of $1.7 million
    - § Higher than budgeted investment and other income of $2.9 million

- February 2019 YTD:
  - Ø $88.3 million surplus
  - Ø $71.0 million favorable to budget
    - § Lower than budgeted revenue of $52.3 million
    - § Lower than budgeted medical expenses of $85.2 million
    - § Lower than budgeted administrative expenses of $17.2 million
    - § Higher than budgeted investment and other income of $21.0 million

Enrollment Summary: February 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
64,541	65,338	(797)	(1.2%)	Aged	513,000	516,428	(3,428)	(0.7%)
590	620	(30)	(4.8%)	BCCTP	4,833	4,960	(127)	(2.6%)
46,995	44,125	2,870	6.5%	Disabled	375,926	370,988	4,938	1.3%
302,286	304,344	(2,058)	(0.7%)	TANF Child	2,469,524	2,501,682	(32,158)	(1.3%)
90,742	93,270	(2,528)	(2.7%)	TANF Adult	743,884	756,651	(12,767)	(1.7%)
3,379	3,525	(146)	(4.1%)	LTC	27,242	27,892	(650)	(2.3%)
236,680	243,242	(6,562)	(2.7%)	MCE	1,897,805	1,938,836	(41,031)	(2.1%)
-	12,502	(12,502)	(100.0%)	WCM*	-	25,004	(25,004)	(100.0%)
745,213	**766,965**	**(21,752)**	**(2.8%)**	**Medi-Cal Total**	**6,032,214**	**6,142,441**	**(110,227)**	**(1.8%)**
14,209	**14,853**	**(644)**	**(4.3%)**	**OneCare Connect**	**116,289**	**119,038**	**(2,749)**	**(2.3%)**
1,472	**1,324**	**148**	**11.2%**	**OneCare**	**11,336**	**10,592**	**744**	**7.0%**
308	**319**	**(11)**	**(3.4%)**	**PACE**	**2,340**	**2,352**	**(12)**	**(0.5%)**
761,202	**783,461**	**(22,259)**	**(2.8%)**	**CalOptima Total**	**6,162,179**	**6,274,423**	**(112,244)**	**(1.8%)**

*Note: Actual members residing in their original aid codes (TANF & SPD) until start of program

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Financial Highlights: February 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
761,202	783,461	(22,259)	-2.8%	Member Months	6,162,179	6,274,422	(112,243)	-1.8%
288,736,739	299,721,674	(10,984,935)	-3.7%	Revenues	2,207,848,429	2,260,160,814	(52,312,385)	-2.3%
255,989,750	275,182,841	19,193,091	7.0%	Medical Expenses	2,060,064,758	2,145,273,675	85,208,917	4.0%
10,727,900	12,392,581	1,664,681	13.4%	Administrative Expenses	83,782,059	100,965,840	17,183,781	17.0%
22,019,089	**12,146,252**	**9,872,837**	**81.3%**	**Operating Margin**	**64,001,611**	**13,921,299**	**50,080,312**	**359.7%**
3,335,666	416,667	2,919,000	700.6%	Non Operating Income (Loss)	24,295,412	3,333,333	20,962,078	628.9%
25,354,755	**12,562,919**	**12,791,836**	**101.8%**	**Change in Net Assets**	**88,297,023**	**17,254,633**	**71,042,391**	**411.7%**
88.7%	91.8%	3.2%		Medical Loss Ratio	93.3%	94.9%	1.6%	
3.7%	4.1%	0.4%		Administrative Loss Ratio	3.8%	4.5%	0.7%	
7.6%	4.1%	3.6%		Operating Margin Ratio	2.9%	0.6%	2.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
20.3	11.6	8.7	Medi-Cal	68.3	20.8	47.5
0.9	0.5	0.4	OCC	(6.1)	(6.5)	0.4
0.3	0.0	0.3	OneCare	(0.1)	(0.5)	0.4
0.5	0.0	0.5	PACE	1.9	0.1	1.9
22.0	**12.1**	**9.9**	**Operating**	**64.0**	**13.9**	**50.1**
3.3	0.4	2.9	Inv./Rental Inc, MCO tax	24.3	3.3	21.0
3.3	**0.4**	**2.9**	**Non-Operating**	**24.3**	**3.3**	**21.0**
25.4	**12.6**	**12.8**	**TOTAL**	**88.3**	**17.3**	**71.0**

Consolidated Revenue & Expense: February 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,533	236,680	745,213	14,209	1,472	308	761,202
REVENUES							
Capitation Revenue	$ 150,927,793	$ 108,033,206	$ 258,960,999	$ 25,277,728	$ 2,078,009	$ 2,420,003	$ 288,736,739
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	150,927,793	108,033,206	258,960,999	25,277,728	2,078,009	2,420,003	288,736,739
MEDICAL EXPENSES							
Provider Capitation	35,630,917	49,622,849	85,253,766	10,243,078	682,194		96,179,038
Facilities	22,448,258	24,635,305	47,083,563	4,252,795	385,769	382,580	52,104,707
Ancillary	-	-	-	653,997	110,907	-	764,904
Professional Claims	17,082,441	6,369,118	23,451,559	-	-	438,212	23,889,771
Prescription Drugs	16,802,850	18,791,105	35,593,955	4,983,116	459,729	190,281	41,227,081
MLTSS	30,767,161	2,964,492	33,731,654	1,087,172	(32,425)	6,964	34,793,364
Medical Management	2,015,733	817,953	2,833,686	1,055,535	54,063	634,475	4,577,759
Quality Incentives	755,379	409,408	1,164,787	276,180		3,080	1,444,047
Reinsurance & Other	494,271	146,536	640,808	200,000	6,202	162,069	1,009,079
Total Medical Expenses	125,997,011	103,756,767	229,753,778	22,751,872	1,666,439	1,817,660	255,989,750
Medical Loss Ratio	83.5%	96.0%	88.7%	90.0%	80.2%	75.1%	88.7%
GROSS MARGIN	**24,930,782**	**4,276,439**	**29,207,221**	**2,525,856**	**411,570**	**602,342**	**32,746,989**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			5,781,343	745,198	28,618	101,852	6,657,011
Professional fees			143,847	3,524	14,667	77	162,114
Purchased services			1,047,637	188,620	16,850	15,633	1,268,740
Printing & Postage			249,380	33,006	5,961		288,347
Depreciation & Amortization			693,950			2,081	696,031
Other expenses			1,293,511	44,721		2,984	1,341,216
Indirect cost allocation & Occupancy			(322,325)	589,123	44,020	3,624	314,442
Total Administrative Expenses			8,887,343	1,604,191	110,116	126,250	10,727,900
Admin Loss Ratio			3.4%	6.3%	5.3%	5.2%	3.7%
INCOME (LOSS) FROM OPERATIONS			20,319,878	921,665	301,454	476,092	22,019,089
INVESTMENT INCOME							3,335,609
OTHER INCOME			58				58
CHANGE IN NET ASSETS			**$ 20,319,936**	**$ 921,665**	**$ 301,454**	**$ 476,092**	**$ 25,354,755**
BUDGETED CHANGE IN NET ASSETS			11,624,280	485,915	11,127	24,930	12,562,919
VARIANCE TO BUDGET - FAV (UNFAV)			$ 8,695,655	$ 435,750	$ 290,328	$ 451,162	$ 12,791,836

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Consolidated Revenue & Expense: February 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,134,409	1,897,805	6,032,214	116,289	11,336	2,340	6,162,179
REVENUES							
Capitation Revenue	$ 1,098,172,599	$ 880,674,076	$ 1,978,846,675	$ 198,939,324	$ 12,859,857	$ 17,202,573	$ 2,207,848,429
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	1,098,172,599	880,674,076	1,978,846,675	198,939,324	12,859,857	17,202,573	2,207,848,429
MEDICAL EXPENSES							
Provider Capitation	286,247,938	402,079,608	688,327,546	90,843,708	3,611,186		782,782,441
Facilities	178,369,114	186,220,944	364,590,058	28,565,640	3,455,183	3,105,220	399,716,100
Ancillary	-	-	-	5,142,566	319,719	-	5,462,286
Professional Claims	127,594,299	50,083,749	177,678,047	-	-	3,469,062	181,147,109
Prescription Drugs	137,237,174	155,557,468	292,794,643	42,911,809	3,724,138	1,352,983	340,783,573
MLTSS	254,716,818	22,518,046	277,234,865	11,083,006	411,497	33,911	288,763,279
Medical Management	16,784,336	8,061,829	24,846,164	8,898,358	494,732	5,011,385	39,250,639
Quality Incentives	6,140,080	3,272,838	9,412,918	2,378,380		23,400	11,814,698
Reinsurance & Other	4,596,740	2,619,483	7,216,223	1,780,245	49,298	1,298,869	10,344,635
Total Medical Expenses	1,011,686,498	830,413,964	1,842,100,463	191,603,711	12,065,753	14,294,831	2,060,064,758
Medical Loss Ratio	92.1%	94.3%	93.1%	96.3%	93.8%	83.1%	93.3%
GROSS MARGIN	**86,486,100**	**50,260,112**	**136,746,212**	**7,335,613**	**794,104**	**2,907,741**	**147,783,671**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			48,111,151	6,061,067	264,647	784,496	55,221,362
Professional fees			1,242,556	218,321	117,334	6,491	1,584,701
Purchased services			5,960,842	1,443,894	120,942	72,845	7,598,523
Printing & Postage			2,505,782	552,917	70,035	47,523	3,176,256
Depreciation & Amortization			3,498,033			16,642	3,514,675
Other expenses			9,599,136	348,497	377	20,510	9,968,521
Indirect cost allocation & Occupancy			(2,423,246)	4,798,423	307,617	35,228	2,718,021
Total Administrative Expenses			68,494,253	13,423,120	880,951	983,735	83,782,059
Admin Loss Ratio			3.5%	6.7%	6.9%	5.7%	3.8%
INCOME (LOSS) FROM OPERATIONS			68,251,959	(6,087,507)	(86,847)	1,924,006	64,001,611
INVESTMENT INCOME							24,294,611
OTHER INCOME			801				801
CHANGE IN NET ASSETS			**$ 68,252,760**	**$ (6,087,507)**	**$ (86,847)**	**$ 1,924,006**	**$ 88,297,023**
BUDGETED CHANGE IN NET ASSETS			20,791,412	(6,476,569)	(456,360)	62,816	17,254,633
VARIANCE TO BUDGET - FAV (UNFAV)			$ 47,461,349	$ 389,062	$ 369,513	$ 1,861,190	$ 71,042,391

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Balance Sheet:
As of February 2019

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$254,989,251	Accounts Payable	$28,207,047
Investments	489,775,756	Medical Claims liability	751,085,844
Capitation receivable	445,247,613	Accrued Payroll Liabilities	11,946,403
Receivables - Other	23,017,885	Deferred Revenue	53,194,800
Prepaid expenses	6,802,558	Deferred Lease Obligations	69,947
		Capitation and Withholds	80,436,376
Total Current Assets	**1,219,833,063**	**Total Current Liabilities**	**924,940,416**
Capital Assets			
Furniture & Equipment	38,297,211		
Building/Leasehold Improvements	5,721,219		
505 City Parkway West	50,260,097		
	94,278,527		
Less: accumulated depreciation	(46,108,158)		
Capital assets, net	48,170,369	Other (than pensions) post employment benefits liability	25,547,203
Other Assets		Net Pension Liabilities	25,305,373
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Board-designated assets			
Cash and Cash Equivalents	27,874,816	**TOTAL LIABILITIES**	**975,792,993**
Long-term Investments	521,739,666		
Total Board-designated Assets	549,614,481	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	549,914,481		
TOTAL ASSETS	**1,817,917,913**	TNE	81,928,057
		Funds in Excess of TNE	768,000,533
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	849,928,590
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,829,050,963**	**TOTAL LIABILITIES & FUND BALANCES**	**1,829,050,963**

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Board Designated Reserve and TNE Analysis
As of February 2019

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	150,338,977				
	Tier 1 - Logan Circle	150,182,421				
	Tier 1 - Wells Capital	149,707,190				
Board-designated Reserve		450,228,589	314,171,327	483,928,207	136,057,261	(33,699,618)
TNE Requirement	Tier 2 - Logan Circle	99,385,893	81,928,057	81,928,057	17,457,836	17,457,836
	Consolidated:	**549,614,481**	**396,099,385**	**565,856,264**	**153,515,097**	**(16,241,782)**
	Current reserve level	*1.94*	*1.40*	*2.00*		

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HN Enrollment Summary - Medi-Cal

Health Network Name	MARCH 2019	% of Total MCAL	% of HN Enrollment
CHOC Health Alliance (PHC20)	146,755	19.7%	22.6%
Monarch Family HealthCare (HMO16)	80,049	10.7%	12.3%
CalOptima Community Network (CN)	76,874	10.3%	11.8%
Arta Western Health Network (SRG66)	63,417	8.5%	9.7%
Alta Med Health Services (SRG69)	48,290	6.5%	7.4%
Family Choice Health Network (PHC21)	45,849	6.1%	7.0%
Kaiser Permanente (HMO04)	45,177	6.1%	6.9%
Prospect Medical Group (HMO17)	34,590	4.6%	5.3%
United Care Medical Network (SRG67)	33,433	4.5%	5.1%
Talbert Medical Group (SRG65)	24,590	3.3%	3.8%
Noble Mid-Orange County (SRG64)	22,859	3.1%	3.5%
AMVI Care Health Network (PHC58)	22,141	3.0%	3.4%
Heritage - Regal Medical Group (HMO15)	6,612	0.9%	1.0%
Total Health Network Capitated Enrollment	**650,636**	**87.2%**	**100.0%**
CalOptima Direct (all others)	95,621	12.8%	
Total Medi-Cal Enrollment	**746,257**	**100.0%**	

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HN Enrollment Summary – OneCare Connect

Health Network Name	MARCH 2019	Percentage
Monarch HealthCare (HMO16DB)	4,686	32.8%
Prospect Medical Group (HMO17DB)	2,432	17.0%
Family Choice Medical Group (SRG81DB)	1,771	12.4%
CalOptima Community Network (CN)	1,696	11.9%
Talbert Medical Group (SRG52DB)	1,051	7.4%
Arta Western Health Network(SRG66DB)	551	3.9%
Alta-Med (SRG69DB)	540	3.8%
United Care Medical Group (SRG67DB)	514	3.6%
Noble Mid Orange County (SRG64DB)	435	3.0%
AMVI Care Health Network (PHC58DB)	429	3.0%
Heritage - Regal Medical Group (HMO15)	193	1.3%
Total OneCare Connect Enrollment	**14,298**	**100.0%**

HN Enrollment Summary - OneCare

Health Network Name	MARCH 2019	Percentage
Monarch HealthCare (PMG53DE)	886	51.1%
AMVI/Prospect Medical Group (PMG27DE)	327	18.9%
Talbert Medical Group (PMG52DE)	149	8.6%
Arta Western Health Network (PMG66DE)	116	6.7%
Family Choice Medical Group (PMG21DE)	103	5.9%
Alta-Med (PMG69DE)	77	4.4%
United Care Medical Group (PMG67DE)	47	2.7%
Noble Mid Orange County (PMG64DE)	29	1.7%
Total OneCare Enrollment	**1,734**	**100.0%**

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CalOptima Behavioral Health Update

Provider Advisory Committee

April 11, 2019

Donald Sharps, M.D.

Medical Director, Behavioral Health

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CalOptima Behavioral Health Integration

- 2018 — CalOptima began directly managing Medi-Cal mental health (MH) / behavioral health treatment (BHT)
  - Ø Member support, provider network, claims and utilization management
  - Ø CalOptima had delegated Medi-Cal MH and BHT to a managed behavioral healthcare organization (MBHO) from 2014 to 2017.
- Magellan MBHO continues to manage OneCare and OneCare Connect (OC/OCC) mental health.
- County mental health (MH) level of care for Medi-Cal unchanged with Affordable Care Act in January 2014

CalOptima BH Integration — Strategic Focus

- Integrated care
  - Ø Mental health screening at primary care settings
  - Ø Psychological factors affecting physical health
  - Ø Co-location of behavioral and physical health services
  - Ø Interdisciplinary care team
- Network development
  - Ø Special populations
  - Ø Specialty areas
- Quality of care
  - Ø Access and availability
  - Ø Member satisfaction

CalOptima Mild to Moderate Outpatient

- Top 10 diagnoses included:
  - Ø Generalized anxiety disorder and unspecified
  - Ø Major depressive disorders — single and recurrent no psychosis
  - Ø Dysthymia
  - Ø Bipolar unspecified
- Diagnoses excluded County Mental Health Plan
  - Ø Intellectual disabilities from mild to profound
    - § If mild to moderate MH impairment, CalOptima offers medication management and counseling for MH needs
    - § If severe MH impairment, CalOptima assists Regional Center of Orange County (RCOC) in linking them to county mental health services

CalOptima Mild to Moderate Outpatient (cont'd)

- 47,012 incoming calls to access a provider
- 18 percent of calls transferred to clinical team for additional support
- Open access with monitoring of appropriate level-of-care and utilization

CalOptima Mild to Moderate Outpatient (cont'd)

- 18,050 average of encounters per month
  - Ø 25,861 unique members in 2018
    - § 4.1 percent yearly penetrance
  - Ø 155 psychiatrists*
  - Ø 32 nurse practitioners*
  - Ø 10 physician assistants*
  - Ø 608 therapists*

- Average Penetrance Rate for under 18
  - Ø Psychotherapy - 0.5% vs 1.0% for over 18
  - Ø Psychiatrist visit – 0.2% vs 1.2% for over 18

*2018 claims data

CalOptima Behavioral Health Treatment (BHT)

- BHT includes Applied Behavior Analysis (ABA)
- 3,662 unique members received ABA in 2018
  - Ø One in 84 <21 year old members received ABA (1.2 percent penetrance)
- Requests for services in 2018
  - Ø 10,117 authorizations
  - Ø 365 modifications and 60 denials
  - Ø 10 state fair hearings
  - Ø Criteria — MCG, APL 18-006, and CalOptima GG.1548
- Eight hours per week average for all ages
- More than 60 providers (CalOptima has met with half)
- Five meetings of ABA Transition Council

Grievances and Appeals

- Top grievance types continue to be delays in service, question of treatment and provider/staff services
  - § Includes delays in results, medication, and referrals; inability to reach provider; member's health concerns were not addressed; poor provider/staff service
  - § Providers within this category are tracked and trended with escalation to Provider Relations, Compliance or Quality Improvement for additional review when required

- Appeals increased significantly from Q2
  - Ø Psychological testing
  - Ø Number of ABA service hours

CalOptima — OCC/OC

- 8,680 incoming calls to access a provider
- 1,067 average encounters per month
  - Ø 1,769 unique members in 2018 (11 percent penetrance)
- 33 psychiatrists/nurse practitioners with claims
- 62 therapists with claims
- Open access with monitoring of appropriate level-of-care and utilization

Drug Medi-Cal Organized Delivery System

- Alcohol Misuse Screening and Behavioral Counseling Interventions (APL 18-014 & APL 17-006)
  - ØReplaced Screening, Brief Intervention, Referral for Treatment
- Medical admits versus voluntary inpatient detoxication(VID)
  - Ø882 Medi-Cal admissions with primary alcohol diagnoses (2016)
  - ØVID is a prior authorized hospitalization (APL 18-001)
- Outpatient drug free
- Intensive outpatient
- Residential
- Social model detoxification
- Medication assisted treatment (MAT) — CalOptima
  - Ø266 prescribers of buprenorphine for CalOptima members (2018)
  - ØTop 10 prescribers with 35 percent of prescriptions

Drug Medi-Cal Organized Delivery System (cont.)

- **Beneficiary Access Line (BAL) July–Dec 2018**
- **631** screenings for clients seeking Drug Medi-Cal services
  - Ø 41 percent of these referrals screened for residential
  - Ø 40 percent of these referrals screened for outpatient
  - Ø 12 percent screened for detox services
  - Ø Six percent screened for Methadone or other MAT
- **354** clients in outpatient contracted programs
  - Ø Last year at this time, they were serving **32** DMC clients
  - Ø Nine contract locations and four county operated sites
  - Ø Medical withdrawal management expanded from one to four days/wk
  - Ø 48 clients have received Vivitrol
- **1,750** clients in methadone programs
  - Ø Providers now include subutex, antabuse and naloxone

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*Beneficiary Access Line (BAL): (800)-723-8641

CalOptima BH Line

- **855-877-3885**
  - Ø Toll-free number for members to access outpatient MH and BHT services
  - Ø Staffed by customer service representatives, licensed behavioral health clinicians, and member liaison specialists
  - Ø Level of care screening
  - Ø Routine with assistance
  - Ø OC/OCC members are connected to Magellan MBHO

CalOptima's Mission

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

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Isabel Becerra
President & CEO

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What is a Community Health Center (CHC)?

Located in areas of high need

Open to all patients

Offer comprehensive set of services

Governed by a patient majority board of directors

1 out of 6 Californians receive care at a community health center.

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Community Health Centers History

- Date back to Lyndon B. Johnson's War on Poverty
  - National movement to bring primary-care to underserved communities
- First Neighborhood Health Centers launched in late 1960s
  - Provide accessible, high-quality health care to everyone who walks through the door, regardless of their ability to pay
- George H. Bush expanded health center funding in late 1980s creating
  - Federally Qualified Health Centers (FQHCs)
  - 340 Drug Pricing Program

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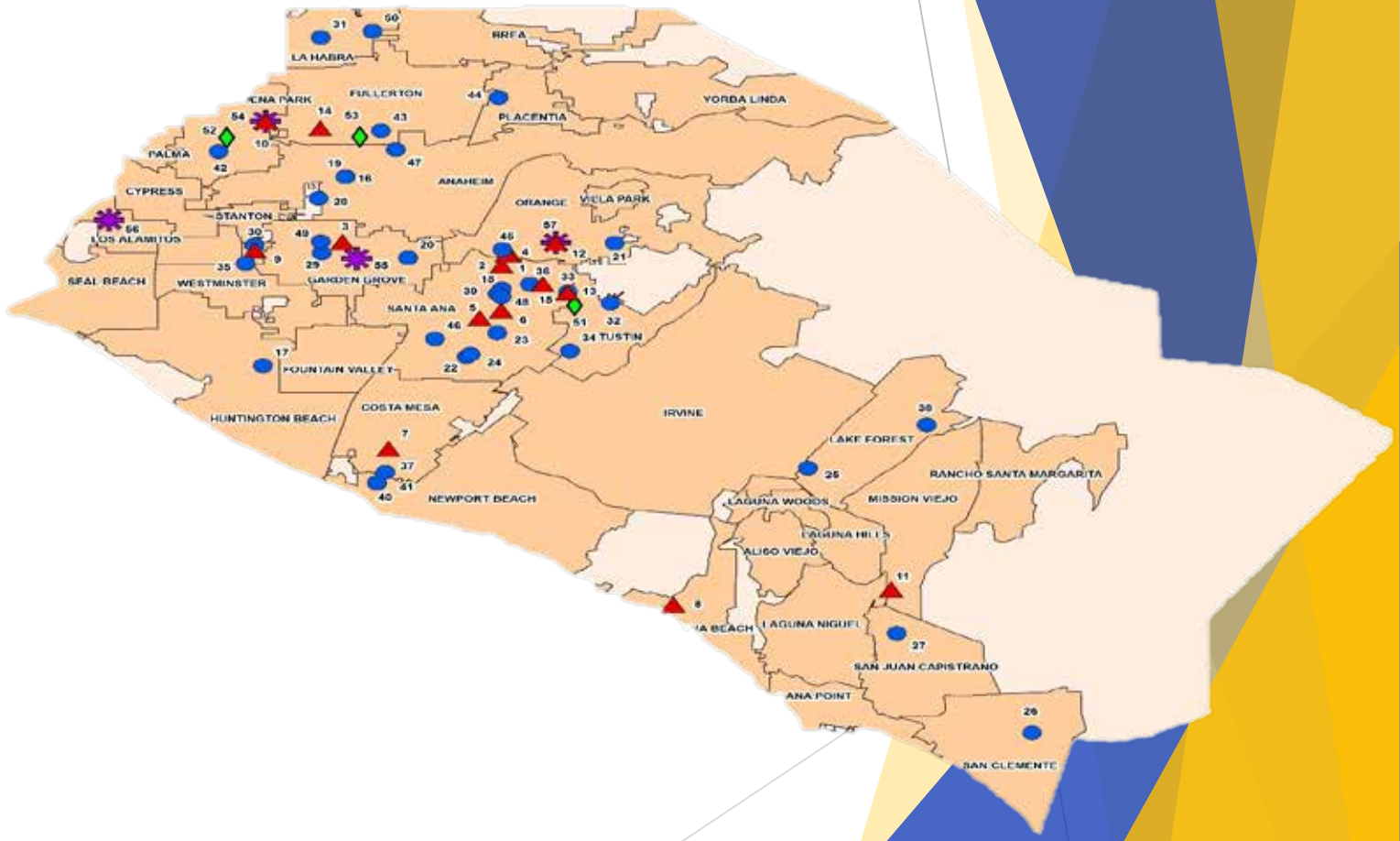
Our Model of Care

- **26 Member Health Centers with 88 sites across OC**
- **41** Federally Qualified Health Center (FQHC) Sites
- **25** Community and Specialty Clinic Sites
- **10** FQHC Mobile Units
- **6** Free Clinic Sites
- **4** FQHC Look-A-Like Sites
- **2** Mobile Clinics



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Community Health Center Patient Demograhics

- **380,000 patients served**
- **>1.1 million annual encounters**
- Patient Demographics:
  - 58% Hispanic
  - 55% < 100% FPL
  - 60% Medi-Cal
  - 29% Uninsured
- Patient Coverage
  - Medi-Cal (59.73 %)
  - Uninsured (28.91 %)
  - Private Insurance (6.63 %)
  - Medicare (2.52 %)
  - Covered CA (0.67 %)
  - Other (1.54 %)

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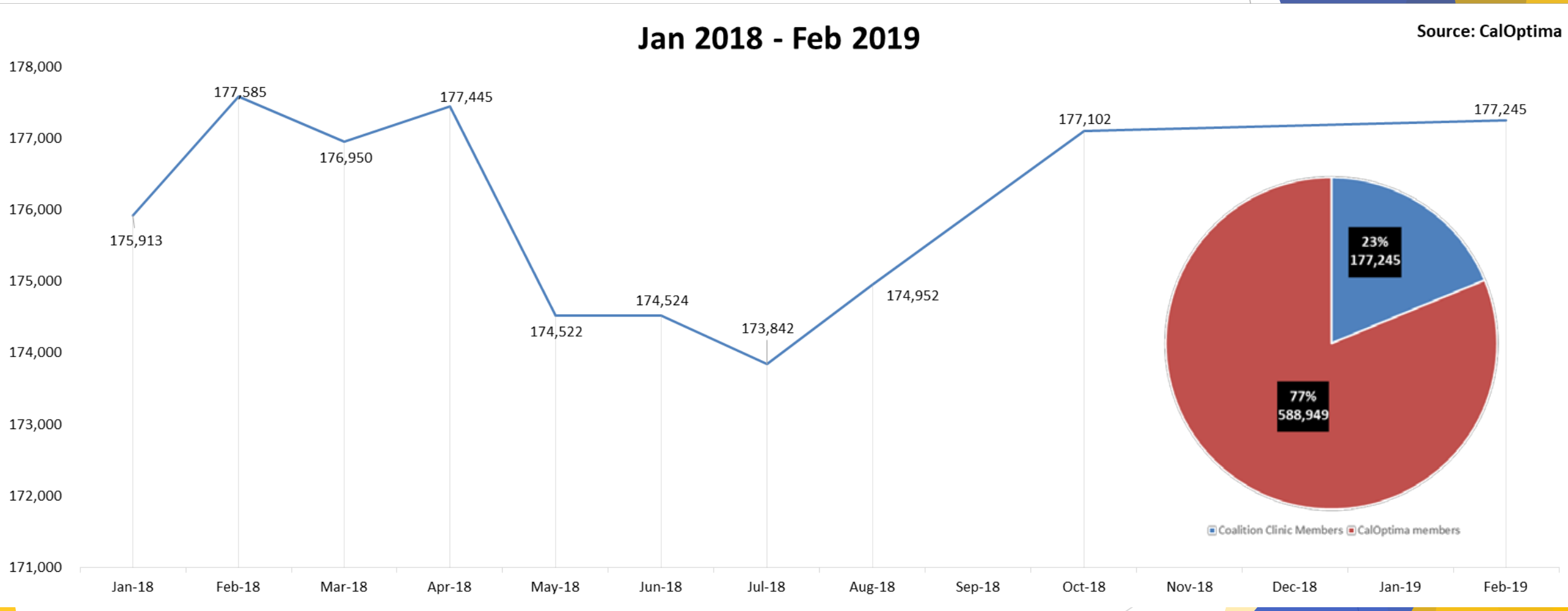
Health Centers and CalOptima Membership



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Health Center Impact in OC: Pre/Post ACA

- Medi-Cal recipients **increased** by **~66%**
- The number of uninsured **decreased** by **~21%**
- Coalition members **opened 13** additional CHC's between 2013 and 2015
- CHC workforce **increases**:
  - Medical Doctors +24.5 FTE
  - Physician Assistants +13.7 FTE
  - Nurse Practitioners +6.2
- Although millions of people have gained access to healthcare, **over 500,000** people **remain uninsured** in Orange County as of 2015!!!

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HRSA Health Center Quality Improvement
FY 2017 Grant Awards (August 2017)

Health Center Grantee	EHR Reporters	Clinical Quality Improvers	CHC Quality Leaders	National Quality Leaders	Enhancing Access to Care	Delivery of High Value Health Care	Addressing Health Disparities	Achieving PCMH Recognition	Total Dollars Awarded
AltaMed Medical Group	$10,500	$108,261	$117,711	$0	$5,250	$0	$73,500	$180,000	**$495,222**
Camino Health Center	$10,500	$16,684	$0	$0	$10,500	$0	$21,000	$30,000	**$88,684**
Central City CHC	$0	$22,905	$0	$0	$0	$0	$0	$0	**$22,905**
Friends of Family HC	$0	$19,330	$32,981	$65,961	$5,250	$0	$0	$30,000	**$153,522**
Hurtt Family Health Clinic	$10,500	$9,207	$0	$0	$0	$0	$0	$0	**$19,707**
Nhan Hoa	$10,500	$14,463	$26,013	$0	$5,250	$0	$21,000	$30,000	**$107,226**
Serve the People CHC	$0	$18,594	$0	$0	$10,500	$0	$0	$30,000	**$59,094**
Share Our Selves	$10,500	$16,707	$28,258	$0	$21,000	$0	$34,125	$30,000	**$140,590**
Southland HC (VNCOC)	$10,500	$14,563	$17,713	$0	$0	$0	$0	$30,000	**$72,776**
St. Jude Neighborhood HC	$10,500	$20,420	$0	$0	$5,250	$0	$34,125	$30,000	**$100,295**
UCI Family Health Center	$0	$26,647	$0	$0	$10,500	$0	$0	$0	**$37,147**
								Grand Total	**$1,297,168**

*Source - https://bphc.hrsa.gov/programopportunities/qualityimprovement/awards.aspx?state=CA

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Our Mission

The Coalition of Orange County Community Health Centers is a consortium of safety net providers and key partners creating quality healthcare for vulnerable, underserved communities.

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Community Health Centers in Orange County: Emergence of the Coalition

- 10 community clinic EDs/Clinic Managers came together to share best practice
- Key Issues:
  - No collective voice at county level
  - No collaborative funding pools
  - Lack of trust among members
  - Service area disputes
  - Lack of leadership

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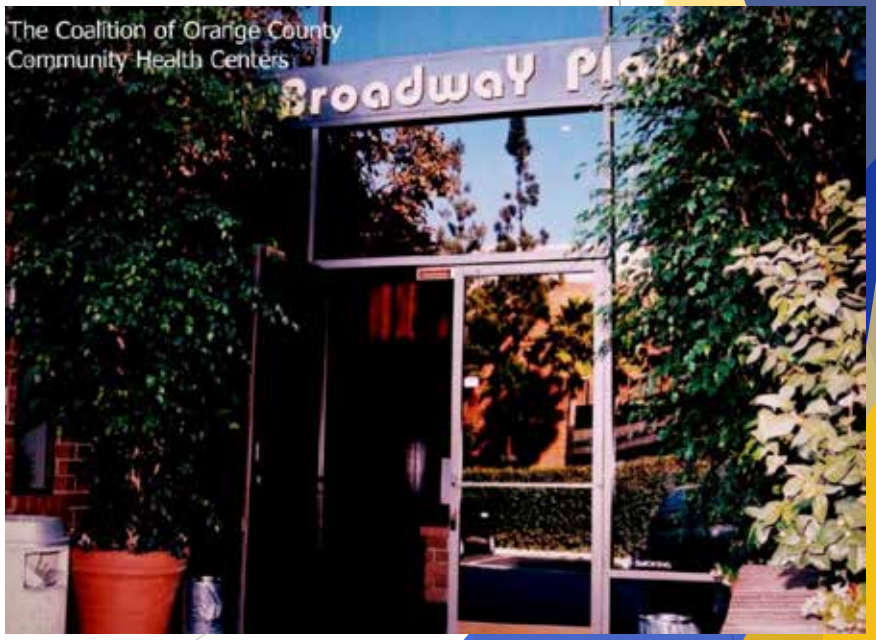
The Coalition History

- 1974
  - Incorporated, volunteer staff, 0.25 FTE - Executive Director
- 1990
  - First funding from local health care agency for full-time Executive Director
  - First concrete efforts of coalescing clinics for collaborative funding opportunities and local policy activities initiated
- 1995
  - Funding from foundations including: Kaiser Permanente, California Wellness, and California Endowment
  - Staff grew to 4
- 1996-1998
  - Staff grew to 10 with Medi-Cal and Healthy Families outreach workers



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The Coalition History

- In 2000, OC passed Measure H
  - Created Tobacco Settlement Fund (TSR) to allocate $ to healthcare
- Coalition selected to oversee TSR funds for community clinics
- Staff grew to 17
- Restructured Board of Directors to include community stakeholders
- Started the development of practice management system (CCPro.net)

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Programs

- Quality Management
- Health Center Controlled Network (HCCN)
- Patient Center Medical Home (PCMH)
- Healthcare Navigators
- OC AHEC- Health Scholars Program
- Dental Transformation Initiative
- Advocacy

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Advocacy and Policy

- Key Players
  - Local
    - OC Board of Supervisors, OC Health Care Agency, CalOptima, Community Organizations
  - State
    - State Budget, California Primary Care Association (CPCA)
  - Federal
    - Community Health Center Funding - Congress, Health Resources & Services Administration (HRSA), National Association of Community Health Centers (NACHC)
- Policy Priorities
  - Medicaid
  - Federal Grant Funding
  - 340B Drug Pricing Program
  - Behavioral Health and Substance Use Disorders (SUD)

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State Priorities

californiahealth+ advocates

- **SB 66 (Atkins) Same Day Billing**: This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.
- **AB 1494 (Aguiar-Curry) Declared Emergencies**: This bill would provide, that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic, is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a state of emergency, as specified. The bill would authorize the department to apply this provision to services provided by another enrolled fee-for-service Medi-Cal provider, clinic, or facility.
- **AB 899 (Wood) Provisional Licensure**: This bill would authorize a licensed primary care clinic with a license in good standing with the department for the preceding 5 years to acquire ownership or control of an outpatient setting or a previously licensed primary care clinic. A licensed primary care clinic that acquires another facility pursuant to this provision be deemed compliant with the minimum standards of adequacy and safety required for the acquired facility.
- **AB 1105 (Gipson) Strengthen Sickle Cell Disease Services**: (CIBD) The bill directs the California legislature to make $15 million available to create a variety of new services for Californians with sickle cell disease (SCD) over the next three years.
- **AB 4 (Arambula/Bonta/Chiu) / SB 29 (Durazo) Health4All Regardless of Immigration Status:** Extends eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status.

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Advocacy Collaborative's & Projects

- Health4All
- Orange County Opportunity Initiative (OCOI)
- Covered OC
- Civic Engagement
  - Voter Registration
  - Census 2020
- Community Events and Town Halls

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Workforce Development

- Area Health Education Center
  - AHEC Scholars Program graduate students
  - Health Scholars Program
  - Chief Medical Officer Track

- *Creating the next generation of healthcare leaders by training undergraduate students, medical students, and family medicine residents in meaningful clinical experiences and community service. Our program aims to address the healthcare shortage by providing a pipeline of mentorship and professional development.*

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Health Scholars Program (HSP)

To provide a quality, individually tailored, clinical experience for undergraduate and post-baccalaureate students with a passion in pursuing health careers in medically underserved communities. Under the AHEC umbrella is our HSP, a workforce pipeline clinical program that engages college graduates interested in health careers and provides opportunities such as student internships and clinical placements.

- Academic Advising Mentoring
- Hands On Clinical Experience
- Leadership Opportunities at Community Health Centers
- Professional Development Workshops
- 100% Health Scholars who applied to graduate school have been admitted to medical & health professional schools.
- 70% Health Scholars enrolled in UC Medical Schools

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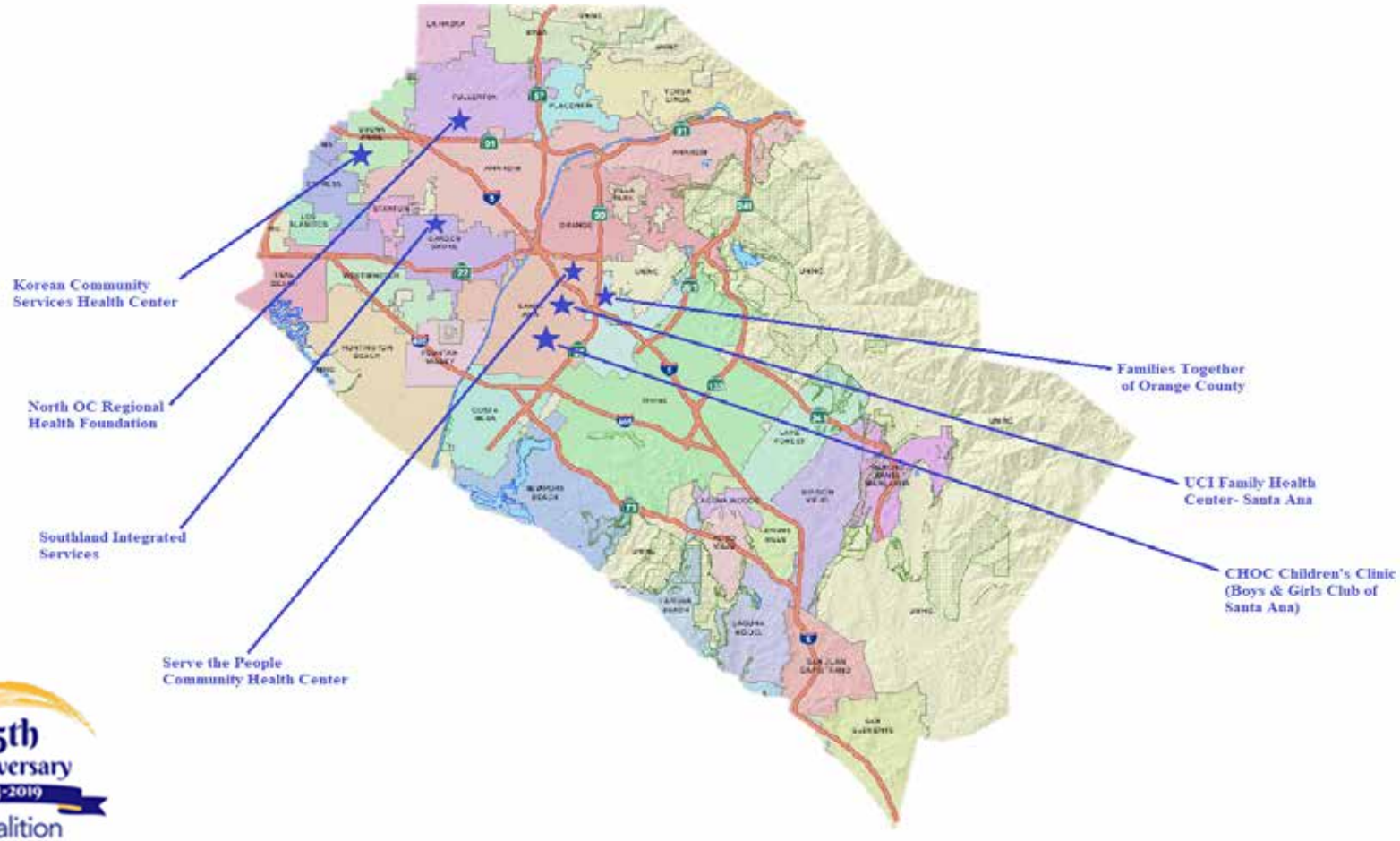
HEALTH SCHOLARS PROGRAM
CHC Placement



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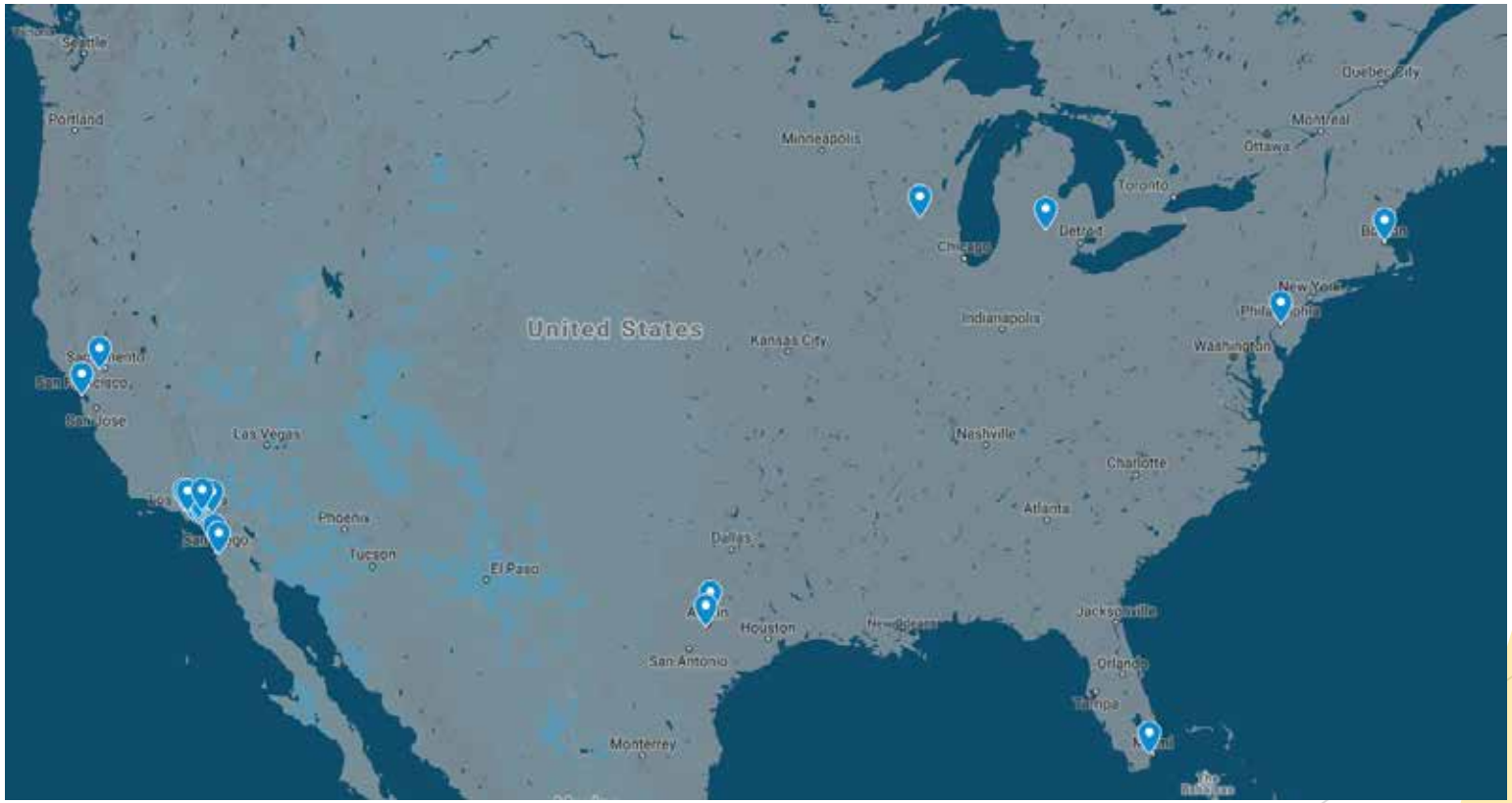
Health Scholars Program-Medical School Acceptance



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CalOptima Board of Directors'
Provider Advisory Committee

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 18/19)	2nd Quarter (Oct - Dec 18/19)	Results of PAC Activities for Period
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	**1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set establish a goal to improve HEDIS performance metrics PAC Members to discuss ideas collected from their constituencies to develop a plan to reach the goal 3) Coordinating data from community and CalOptima using CalOptima's data warehouse	PAC members received a HEDIS and CAHPS Update for 2018 PAC reviewed the Board request for review of the Delivery System and auto assigment changes at their September 2018 meeting PAC requested a joint meeting with MAC and OCC MAC to review the Board directive	PAC along with MAC received a request from the Board to review CalOptima's current delivery system and make recommendations on possible changes Both MAC and PAC considered recommendations at a special joint meeting in October 2018 that was reported to the CalOptima BOD at the November meeting	**PAC and MAC committees opposed the BOD proposal to review the current delivery system based on 1) there was no clear estimate of the cost and concerns were raised about the drain on CalOptima's resources. The MAC opposed based on there was no clear understanding what the intent of this review was for and the cost .**
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	1) Monitor access and coordination of behavioral health and medical services through regular updates from CalOptima and Magellan 2) Continue Whole Person Care Model updates 3) PAC continued to receive updates at every PAC meeting from CalOptima Executives regarding the transition of the behavioral health services	PAC members received regular Whole-Child Model updates PAC members also received regular updates on Palliative Care	PAC members continued to receive regular updates on the WCM and the HHP They also received information on Whole-Person Care	PAC will continue to be updated on these important programs
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	PAC will provide input into IGT funding recommendations prior to board approval	At the August PAC meeting staff presented the status of the approved IGT funding categories for IGT 6&7 The PAC was also provided a status on IGT funding for 1-5	PAC members received a update on the Be Well Wellness Hub PAC members received an update on the $11 4M IGT 5 funds and how it would be used in this endeavor	

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CalOptima Board of Directors'
Provider Advisory Committee

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 18/19)	2nd Quarter (Oct - Dec 18/19)	Results of PAC Activities for Period
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	**1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.**	PAC Members to identify three (3) burdensome administrative pain points to improve efficiencies and work with CalOptima Staff to address these	This item was identified in 2017 and is no longer valid	N/A	N/A
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set establish a goal to improve HEDIS performance metrics PAC Members to discuss ideas collected from their constituencies to develop a plan to reach 3) Coordinating data from community and CalOptima using CalOptima's data warehouse	Update on Pay for Value is part of the Chief Medical Officer Report	On-going	PAC will receive a Pay for Value report during the fiscal year
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	1)Explore ideas to broaden access for hard to find providers 2	PAC received regular financial updates from the CFO	PAC continued to receive regular finanical updates	

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CalOptima Board of Directors'
Provider Advisory Committee

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 18/19)	2nd Quarter (Oct - Dec 18/19)	Results of PAC Activities for Period
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	**1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.**	1) Provide timely input on key issues prior to Board decision	This issue was identified to be discussed at a joint meeting or a regular meeting of the PAC	PAC receives regular updates at meeting by the Network Operations Executive Director	
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	Hold a joint MAC/PAC Meeting once a year to share information if MAC is agreeable	A joint meeting is scheduled with the four advisory committees in November 2018	A joint meeting was held November 8, 2018 to discuss agenda items of mutual interest between the MAC, OCC MAC, PAC and the new WCM FAC committee	MAC and PAC have agreed to hold a joint meeting one every fiscal year
		3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.	Review quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers	PAC received Medi-Cal and OneCare HEDIS 2017 results for 2016 data at the August meeting OneCare Connect baseline results were also presented Next steps were discussed to implement strategies of low performing results PAC received informative presentations from other PAC member	On-going	PAC receives regular and timely reports from CalOptima staff as necessary on HEDIS
III. Partnership and Engagement (Cont.)	**Engage providers and community partners in improving the health status and experience of our members (Cont.)**	**4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.**	Support Board and CalOptima to proactively respond to ACA, OCC and Cal MediConnect changes 1) PAC Chair shared information with CAPG/APG in the past	On-going	On-going	PAC continues to share significate CalOptima news with the consitutents they represent

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CalOptima Board of Directors'
Provider Advisory Committee

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	1st Quarter (Jun - Sep 18/19)	2nd Quarter (Oct - Dec 18/19)	Results of PAC Activities for Period
Charge of the Advisory Committees pursuant to Resolution No 2-14-95:						
1 Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board						
2 Engage in study, research and analysis on issues assigned by the Board or generated by the committees						
3 Serve as liaisons between interested parties and the Board						
4 Assist the Board in obtaining public opinion on issues related to CalOptima						
5 Initiate recommendations on issues of study to the Board for their approval and consideration						
6 Facilitate community outreach for CalOptima and the CalOptima Board						

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CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2018-2019

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	3rd Quarter (Jan - Mar 2019)	4th Quarter (Apr - Jun 2019	Results of PAC Activities for Period
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	**1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to establish goals to improve HEDIS performance metrics PAC Members to discuss ideas collected from their constituencies to develop a plan to reach these goals 3) Coordinating data from community and CalOptima using CalOptima's data warehouse 4) PAC will receive a presentation at the joint MAC/PAC/OCC MAC meeting on March 8, 2018	Dr Ramirez shared his ideas on what may improve Quality He believes that member and provider incentives make a difference in improving the outcome of HEDIS metrics He is also interested in pursuing Telehealth initatives to improve access to certain specialists CalOptima is waiting for final guidance on this from DHCS		
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	1) Monitor access and coordination of behavioral health and medical services through regular updates from CalOptima and Magellan 2) Continue Whole Person Care Model updates 3) PAC continued to receive updates at every PAC meeting from CalOptima Executives regarding the transition of the behavioral health services	**February meeting:** PAC received an Opioid Crisis update from David Ramirez, M D , CalOptima CMO PAC also received updates on Whole Child Model, Health Homes Project and Whole Person Care PAC received information on the Denti-Cal Initiative **March meeting:** PAC received an update on Homeless Health and Behavorial Health		
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	PAC will provide input into IGT funding recommendations prior to board approval	PAC received an IGT 5 update at the February PAC Meeting		

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CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2018-2019

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	3rd Quarter (Jan - Mar 2019)	4th Quarter (Apr - Jun 2019	Results of PAC Activities for Period
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	**1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.**	PAC Members to identify three (3) burdensome administrative pain points to improve efficiencies and work with CalOptima Staff to address these	CalOptima staff is working with the health networks to improve the sharing of data through the submission of XML files This project is slated to go live in 2019		
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set establish a goal to improve HEDIS performance metrics PAC Members to discuss ideas collected from their constituencies to develop a plan to reach 3) Coordinating data from community and CalOptima using CalOptima's data warehouse	**March meeting:** PAC had a presentation on the Proposed Health Network Quality Performance Rating Methodolgy PAC members had questions about the data and requested each health network receive their actual data to understand the impact PAC asked to be provided updates as the program evolves		
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	1)Explore ideas to broaden access for hard to find providers 2) PAC members slated this as an agenda item at the upcoming MAC/PAC/OCC PAC meeting on March 8, 2018	PAC members receive regular financial reports		

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CalOptima Board of Directors'
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GOALS AND OBJECTIVES FY 2018-2019

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	3rd Quarter (Jan - Mar 2019)	4th Quarter (Apr - Jun 2019	Results of PAC Activities for Period
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	**1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.**	1) Provide timely input on key issues prior to Board decision 2) PAC members slated this as an agenda item at the upcoming MAC/PAC/OCC PAC meeting on March 8, 2018			
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	Hold a joint MAC/PAC Meeting once a year to share information if MAC is agreeable			
		3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.	Review quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers			

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GOALS AND OBJECTIVES FY 2018-2019

CalOptima Strategic Priority	CalOptima Goals	CalOptima Objectives	PAC Activities	3rd Quarter (Jan - Mar 2019)	4th Quarter (Apr - Jun 2019	Results of PAC Activities for Period
III. Partnership and Engagement (Cont.)	**Engage providers and community partners in improving the health status and experience of our members (Cont.)**	**4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.**	Support Board and CalOptima to proactively respond to ACA, OCC and Cal MediConnect changes 1) PAC Chair shared information with CAPG/APG in the past	PAC members requested CalOptima staff present on the status of the appropriate vs non-appropriate use of the ER by CalOptima members		
Charge of the Advisory Committees pursuant to Resolution No 2-14-95:						
1 Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board						
2 Engage in study, research and analysis on issues assigned by the Board or generated by the committees						
3 Serve as liaisons between interested parties and the Board						
4 Assist the Board in obtaining public opinion on issues related to CalOptima						
5 Initiate recommendations on issues of study to the Board for their approval and consideration						
6 Facilitate community outreach for CalOptima and the CalOptima Board						

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2019–20 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 652 Blumenauer	**Programs of All-Inclusive Care for the Elderly (PACE) Final Rule:** Directs the Secretary of Health and Human Services (HHS) to release the final PACE rule (81 Fed. Reg. 54666) no later than April 1, 2019, which would implement the first update to PACE regulations in more than ten years. The proposed changes include allowing PACE organizations (POs) to, (1) include community-based physicians as part of their interdisciplinary teams (IDTs); (2) use nurse practitioners and physician assistants as primary care providers; (3) provide services in settings other than the PACE Center, and; (4) configure the IDT to meet the needs of individual participants. Taken together these changes are likely to enable POs to accommodate more participants and expand their programs without compromising quality of care. CalOptima PACE has been an early adopter of many of the PACE innovations reflected in the final rule, applying for Centers for Medicare & Medicaid Services (CMS) exemptions to utilize community-based physicians, nurse practitioners, and the Alternative Care Setting (ACS) model to deliver PACE care outside of the PACE center. Updating the PACE regulations to allow these innovations to be part of the program will facilitate growth and sustainability for the PACE model.	**01/17/2019** Introduced; Referred to Ways and Means; Energy and Commerce	NPA – Support

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula SB 29 (Lara/Durazo)	**Medi-Cal Eligibility Expansion:** Extends eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Department of Health Care Services (DHCS) projects this expansion would cost approximately $1.6 billion General Fund (GF) each year; $1.5 billion by expanding full-scope Medical up to age 64 and $115 million by expanding to adults 65 years of age and older. Additionally, the cost of In-Home Supportive Services (IHSS) for undocumented young adults with disabilities would cost $2.2 million GF each year. The cost of IHSS for undocumented seniors has yet to be calculated. Under the terms of SB 75, signed into California state law in 2015, children under 19 years of age, regardless of their immigration status, became eligible for full-scope Medi-Cal benefits, as long as they meet all other eligibility requirements. This change in state policy brought approximately 9,000 new members in to CalOptima. Similarly, AB 4/SB 29 would likely increase CalOptima's Medi-Cal membership. Of note, the Governor's 2019-20 Budget Proposal includes a provision to expand full-scope Medi-Cal to undocumented individuals, but only for ages 19 to 25. According to a DHCS analysis, the Governor's proposed 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 GF ($260 million total) in fiscal year 2019-20. A similar analysis of AB 4/SB 29's impact is likely to be produced as these bills are heard in their respective committees of jurisdiction.	**12/03/2018** Introduced	Watch
AB 316 Ramos/Rivas	**Medi-Cal Dental Services Reimbursement:** Would increase the fee-for-service reimbursement rate for Denti-Cal providers that provide services to individuals with special needs. Pending approval from the Centers for Medicare & Medicaid Services (CMS), the increase in reimbursement rates to Denti-Cal providers would allow the provider to be reimbursed for the additional time and resources required to treat a patient with special needs. Providers are currently not receiving additional funds if a patient with specials needs uses more time and resources than originally allocated. The increase in reimbursement rate has yet to be defined. Since Denti-Cal is a Medi-Cal managed care "carve-out," CalOptima does not provide dental benefits to our Medi-Cal members. However, CalOptima is tracking this bill due to its potential impact on our members who access dental benefits on a fee-for-service basis as part of the Denti-Cal program.	**01/30/2019** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 318 Chu	**Materials for Medi-Cal Members:** Similar to AB 2299, introduced and vetoed by the Governor in 2018, requires all Medi-Cal managed care plans' (MCPs) written health education and information materials to be reviewed through "field testing" to ensure all materials meet readability and suitability standards. Field testing may be conducted internally by the MCP or by an external entity. The findings of the field testing will then be reported to the Department of Health Care Services (DHCS). Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. The timeline to complete the field test report has yet to be defined. Currently, CalOptima's Health Education and Cultural Linguistic Services departments review all informational materials released to members in all threshold languages. To ensure the quality of the translation, CalOptima and its Health Networks participate in a robust process to ensure cultural and linguistic appropriateness, including: qualified translators, editor for translated documents, and having the translated documents translated back to English to check the accuracy of the translation, as necessary. This bill proposes to add an additional step—field test reports to DHCS—in addition to the current process.	**01/30/2019** Introduced	Watch
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement:** Similar to SB 1125, introduced and vetoed by the Governor in 2018, would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow for reimbursable mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Although there is no direct impact to CalOptima given that the FQHC "wrap around" prospective payment system (PPS) reimbursement is administered by the state, the policy change would impact access to services that our members receive at FQHCs. LHPC supported SB 1125 in 2018.	**01/08/2019** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 163 Portantino	**Qualifications for Autism Spectrum Disorder (ASD) Providers:** Similar to SB 399, introduced and vetoed by the Governor in 2018, would revise and expand the definitions of those providing care and support to individuals with Autism Spectrum Disorder (ASD) and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment would be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider and the authorization of ASD treatment services would not be declined if a parent or caregiver is unable to participate. This would significantly limit CalOptima's ability to determine medically necessary services. Furthermore, without parent or caregiver participation, the ability to manage the child's behavior as well as the success of the treatment would be limited. CAHP and LHPC opposed SB 399 in 2018, asserting that the provisions resulted in a disregard of current medical recommendations and evidence-based practice guidelines.	**02/06/2019** Referred to Committees on Health and Human Services **01/24/2019** Introduced	Watch
SB 175 Pan	**State-Based Individual Mandate:** Would create a state-based individual mandate, to require all California residents to be enrolled in a health insurance plan. A fine would be charged to each resident for each month that person is not insured. The bill language does not currently define the penalty fee amount. H.R. 1 (P.L. No: 115-97), passed by Congress in 2017, eliminated the penalty associated with the Affordable Care Act's individual mandate, effective January 1, 2019; therefore, there is currently a zero-dollar fine if a California resident is not insured. As a result, the California Legislative Analyst's Office (LAO) reported that 24 percent fewer people enrolled in Covered California in 2019 when compared to 2018 enrollment data. While there is no direct impact to CalOptima, since it does not operate in the individual market, the provisions would have a wide-ranging impact on the health care system as a whole. Individuals who are just above the Medi-Cal eligibility threshold often "churn" back and forth between Covered California and CalOptima and SB 175 could potentially impact this population.	**02/06/2019** Referred to Committees on Health and Governance & Finance **01/28/2019** Introduced	Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

NPA: National PACE Association
CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: February 20, 2019

2019 Federal Legislative Dates

January 3	116th Congress convenes 1st session
April 15–26	Spring recess
July 29–September 6	Summer recess
September 30–October 11	Fall recess

2019 State Legislative Dates

January 7	Legislature reconvenes
February 22	Last day for legislation to be introduced
April 26	Last day for policy committees to hear and report bills to fiscal committees
May 3	Last day for policy committees to hear and report non-fiscal bills to the floor
May 17	Last day for fiscal committees to report fiscal bills to the floor
May 28–31	Floor session only
May 31	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 12–August 9	Summer recess
August 30	Last day for fiscal committees to report bills to the floor
September 3–13	Floor session only
September 13	Last day for bills to be passed. Final recess begins upon adjournment
October 13	Last day for Governor to sign or veto bills passed by the Legislature
December 2	Convening of the 2020–21 session

Sources: 2019 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

WHOLE-CHILD MODEL FREQUENTLY ASKED QUESTIONS

FOR CCS-PANELED AND CCS-APPROVED PROVIDERS

We appreciate your partnership and commitment to serve our members. The following will assist in answering questions regarding the Whole-Child Model program.

1. **What is the Whole-Child Model (WCM) program?**

   The WCM program is designed to help children ages up to 21 years eligible for California Children's Services (CCS) and their families get better care coordination, access to care and improved health results. Prior to July 1, 2019, children with CCS-eligible diagnoses were enrolled in and received care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions.

   Senate Bill (SB) 586 authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated counties. Twenty counties are affected by the WCM program:

WCM Managed Care Health Plans	WCM Counties
Phase 1 — July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Phase 2 — January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo
Phase 3 — July 1, 2019	
CalOptima	Orange

2. **What will happen to children currently receiving CCS who are not CalOptima members?**

   CCS services for non-CalOptima members will remain the responsibility of the local CCS program administered by the Orange County Health Care Agency (OC HCA).

3. **Who will determine CCS eligibility?**
   The local CCS program will retain responsibility for determining CCS program eligibility. Note that CCS eligibility is separate from Medi-Cal eligibility. Members will need to continue to work with the Orange County Social Services Agency regarding Medi-Cal eligibility.

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4. **What is the provider process to refer for CCS eligibility?**

   If the condition needing treatment is for a new, CCS-potentially eligible condition, the provider should submit a completed CCS Service Authorization Request (SAR) and pertinent medical reports needed to the member's health network (including CalOptima Direct and CalOptima Community Network).

   For CalOptima members, SARs submitted directly to the local CCS program will be processed for medical eligibility determination only. Authorization for treatment must be directed to the member's health network (including CalOptima Direct and CalOptima Community Network).

5. **Who will provide CCS services under the WCM program?**

   In Orange County, CalOptima and its delegated health networks will be responsible for coordinating and authorizing CCS services consistent with its current processes.

   CCS services will be provided by CCS-paneled and CCS-approved providers. If a specialist is not a part of CalOptima's network and/or located outside the county, CalOptima or one of its health networks will be responsible for coordinating and approving those services, as appropriate.

6. **Is a CCS-paneled specialist able to act as a primary care provider (PCP) for their CCS-eligible member?**

   Yes, a CCS-eligible member, or their parent/guardian, may request their CCS-paneled specialist act as their PCP. Call CalOptima or the member's assigned health network for more information, as this arrangement is contingent on the specialist provider's contract.

7. **What if I am not a CCS-paneled provider?**

   DHCS requires certain provider types to be CCS-paneled or CCS-approved in order to treat CCS-eligible conditions. This requirement will continue to apply under WCM. Not all provider types have to be paneled. You can find CCS program participation requirements by provider type at the DHCS webpage: https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

   Details about how to become a CCS-paneled provider are at the DHCS webpage: http://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

8. **What do I do if I am not part of CalOptima's network?**

   All CCS providers are encouraged to contact CalOptima and its delegated health networks about contracting. Our provider manual includes contact information for our internal departments and our delegated health networks. You can also contact the CalOptima Provider Relations department to speak to a representative at **714-246-8600**.

9. **How will my patients know if their CCS benefits will transition under WCM?**

   CalOptima members currently receiving CCS services will receive a 90-day notice from CalOptima starting around April 1, 2019, and a 60-day notice starting around May 1, 2019. CalOptima will send notices prior to the effective date with a similar message approved by DHCS. Beginning May 10, 2019, CalOptima will also reach out by phone (up to five calls) to impacted members to inform them of any changes.

10. Will the same benefits be covered in the WCM program?

CCS benefits remain the same under WCM. Most CCS benefits will be provided through CalOptima and its health networks.

Services carved-out of coverage by CalOptima will continue to be administered as they are today. The carved-out benefits include the Medical Therapy Program (MTP), and all CCS services for non-Medi-Cal members. Please contact the local CCS program administered by OC HCA at 714-347-0300 for questions related to carved-out benefits.

11. Will children still receive Palliative Care Services through the Pediatric Palliative Care Waiver?

The Pediatric Palliative Care Waiver program ended on December 31, 2018. Beginning January 1, 2019, children enrolled in CalOptima receive palliative care services through CalOptima or their health network.

12. Will existing CCS members be able to continue to receive care from their current CCS doctors?

CalOptima and its delegated health networks will provide continuity of care for WCM members for up to 12 months. Continuity of care means that a member can continue receiving care from their CCS-paneled providers, if certain criteria are met:

- Member has existing relationship with the provider
- Provider accepts CalOptima's (or health network's) reimbursement rate or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless otherwise agreed; and
- Provider has no quality and credentialing issues

Continuity of care applies to specialists, special care centers and custom durable medical equipment (DME) providers. In addition, continuity of care may also apply to the CCS public health nurse, if available. There is also a provision for continued access to medication until the provider has discontinued the medication or it is no longer needed.

13. As a provider, can I request continuity of care for my patient?

Yes. If you are a CCS-paneled provider currently providing services to a CalOptima member who is CCS-eligible, you may request continuity of care on the member's behalf. Contact CalOptima Customer Service at **714-246-8500** for more information.

14. Will children be able to continue care from their current durable medical equipment (DME) providers?

If the WCM transitioning member has an established relationship with a custom DME provider, CalOptima and its delegated health networks will provide access to that DME provider for up to 12 months. Continuity of care criteria is met if the custom DME:

- Is uniquely constructed or substantially modified solely for the use of the WCM transitioning member
- Is made to order or adapted to meet the specific needs of the WCM transitioning member
- Is uniquely constructed, adapted or modified such that it precludes use by another person and cannot be grouped with other items meant for the same use for pricing purposes

Continuity of care may be extended beyond 12 months for custom DME still under warranty and deemed medically necessary.

15. How do I get authorization for CCS services to be rendered on or after July 1, 2019?

CalOptima Care Network (CCN)/CalOptima Direct (COD)
Requests for CalOptima Direct and CalOptima Community Network members for services requiring prior authorization should be submitted to CalOptima's Utilization Management department by facsimile or through the CalOptima Link portal.

Health Networks
Requests for treatment requiring prior authorization should be submitted to the member's health network.

16. How will claims processes change?

Claims for services provided on and after July 1, 2019, should be sumitted to the member's health network (including CalOptima Direct or CalOptima Community Network), except for the carved-out benefits, such as MTP-related services, which will continue to be authorized by the local CCS program.

For claims directed to CalOptima, both electronic and hard copy formats are accepted.

For questions regarding the submission of claims, contact CalOptima's Claims department at **714-246-8885**

Electronic claims submission: CalOptima has a contract with a clearinghouse to receive electronic data interchange (EDI) claims. There is no cost to you for services provided by our clearinghouse. To register and submit electronically, contact:

Office Ally
866-575-4120
www.officeally.com

(See question #18 for a list of CalOptima health networks and their contact information.)

17. Will CCS rates apply under WCM after the transition?

CalOptima and its health networks are required to pay CCS-paneled providers at rates that are at least equal to CCS fee-for-service rates, unless the provider enters into an agreement on an alternative payment methodology mutually agreed upon.

18. Who do I contact if I have questions about WCM?

Health Network	Phone Number
AltaMed Medical Group	855-848-5252
AMVI Care Health Network	888-747-2684
Arta Western Health Network	310-354-4200
CalOptima Community Network	**714-246-8600**
Children's Hospital Orange County Health Alliance	800-387-1103
Family Choice Health Network	800-611-0111
Heritage Provider Network – Regal Medical Group	800-747-2362
Kaiser Permanente	800-464-4000
Monarch Family HealthCare	888-656-7523
Noble Mid-Orange County	888-880-8811
Prospect Medical Group	800-708-3230
Talbert Medical Group	310-354-4200
United Care Medical Group	877-225-6784

19. How can I stay informed about these changes?

More information about CalOptima's WCM program is available at:
https://www.caloptima.org/en/CCS_Info.aspx