ENVIRONMENTAL SCAN

STRATEGIC PLAN 2020–2022

CalOptima
A Public Agency
Better. Together.

Introduction

CalOptima's mission is "to provide members with access to quality health care services delivered in a cost-effective and compassionate manner," and the health plan's vision is "to be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members." The environment in which the health plan realizes its mission and vision is complex, reflecting the intersection of federal- and state-level priorities with local needs and goals. This document provides an overview of the federal, state and local landscape that sets the stage for the opportunities and challenges to CalOptima's work and interacts with its daily operations and longer-term strategic vision.

The information from the environmental scan has been integrated with the themes and insights obtained from the interviews with CalOptima's Board of Directors, executive team and advisory committees. This provides the framework for the 2020–2022 CalOptima Strategic Plan. The data in the environmental scan is as of July 2019.

CalOptima

In 1993, the Orange County Board of Supervisors created CalOptima as a County Organized Health System (COHS). Initially created to serve the Medi-Cal program, CalOptima currently offers the following four programs:

- Medi-Cal – a public-sector health insurance program that serves low-income individuals and families.
- OneCare Connect Cal MediConnect Plan – a program that serves members eligible for both Medi-Cal and Medicare coverage (i.e., the dual-eligible population). This program combines the Medicare and Medi-Cal benefits into a single plan and offers additional benefits as well.
- OneCare – A Dual Eligible Special Needs Plan (D-SNP) for individuals who qualify for both Medicare and Medi-Cal.
- Program of All-Inclusive Care for the Elderly (PACE) – a community-based program that supports frail seniors by providing coordinated and integrated services to help them continue living independently. PACE provides the acute and long-term care services covered by both Medicare and Medi-Cal.

As of July 2019, CalOptima has more than 750,000 enrollees across the following products:

- Medi-Cal: 739,771
- OneCare Connect: 14,257
- OneCare: 1,530
- PACE: 335[i]

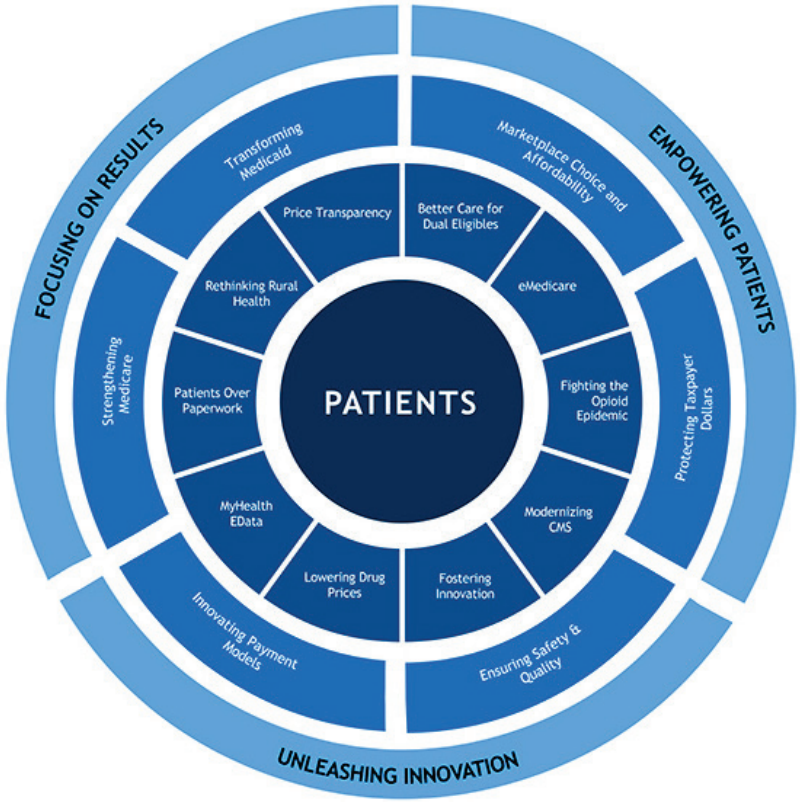
As a COHS plan, CalOptima is the sole Medi-Cal managed care plan in Orange County, which makes it an integral part of the safety net. CalOptima has demonstrated it can take advantage of its unique role and have a direct impact on care delivery, cost and quality for this population. For five years in a row, from 2014–2019, CalOptima received recognition as the top-rated health plan in California for outstanding quality, according to the National Committee for Quality Assurance (NCQA). For 2019–2020, no other health plan received a higher rating. CalOptima's NCQA accreditation was recently renewed at the Commendable level again.

Additionally, CalOptima has continued to explore additional lines of business and pilot programs that are in line with the needs of its community and to test new ways to deliver high-quality care for its members. CalOptima is in a strong strategic position to build on its successes and continue to explore additional ways to support its membership and local community.

Federal Landscape

For the past several years, the federal health policy landscape has been defined by uncertainty, and this will continue into the foreseeable future. This debate could be restarted depending on the outcomes of the 2020 election. Further, lawsuits seeking to repeal the Affordable Care Act (ACA) continue to work their way through the federal court system. The growth in the federal deficit also increases the likelihood of Congressional action to reduce Medicaid and Medicare spending, which could include converting Medicaid financing into a block grant or per capita cap structure.

The Centers for Medicare & Medicaid Services (CMS), which provides the federal funding and oversight for the Medicaid program, has established 16 strategic initiatives, which are shown below.[ii]



The CMS strategic priorities are focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. These priorities can be used to guide how CalOptima can strategically position itself and prepare to proactively work toward the CMS goals. They also provide insights about potential areas of focus at the federal level for both Medicaid and Medicare. The ability to anticipate changes at the federal level and minimize the disruption caused by the implementation of new federal requirements and initiatives will allow CalOptima to be proactive and innovative.

In separate but relevant activity, the federal Administration's recent actions related to public programs may have a negative impact on total Medicaid enrollment. A recent fact sheet from the Kaiser Family Foundation notes concerns about current immigration policy and the impacts on enrollment in public sector programs (including Medicaid) by lawfully present immigrants, citizen children immigrants and undocumented populations.[iii] The recently published "public charge" rule is also likely to lead to a decline in Medicaid enrollment as it expands the programs used to deem a legal immigrant a "public charge" (which can make it more difficult for an individual to gain legal permanent residency status or obtain a visa to enter the U.S.) to include Medicaid.[iv] It is expected the public charge rule will be challenged in court, but the Medicaid enrollment impacts in California may be felt more immediately than this issue can be resolved.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Newsom in November 2018. The appointment of a consumer-focused and innovative health policy team demonstrates that the Governor intends to continue to drive significant changes across the health care landscape in California. Newsom has an ambitious health care agenda that includes moving California to some form of universal coverage. Additionally, the Newsom Administration

has used its health care platform to take several significant actions in its first six months:

- Appointment of Nadine Burke Harris, M.D., as the first Surgeon General for California. Surgeon General Dr. Burke Harris has a strong focus on how Adverse Childhood Experiences (ACE) and social determinants of health impact health outcomes
- Appointment of Tom Insel as the first state Mental Health Czar with a directive to develop a blueprint to address behavioral health issues across the state
- Release of an Executive Order on bulk pharmacy purchasing to reduce rising prescription drug costs, including the carve-out of pharmacy from Medi-Cal managed care plans
- Release of an Executive Order that calls for the development of a "Master Plan for Aging" by October 2020 with input from a Cabinet-Level Workgroup that will work with a Stakeholder Advisory Committee comprised of a diverse set of stakeholders with both a research and long-term care subcommittee structure
- Establishment of the Healthy California for All Commission to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system for all Californians
- Enactment of a provision to expand full scope Medi-Cal coverage for undocumented adults up to age 26 using state General Funds to cover the costs of enrollment and coverage
- Enactment of a California-specific individual mandate penalty and increased subsidies for individuals and families above the ACA amounts to provide stability in the individual insurance market and increase coverage for individuals with incomes above the Medi-Cal eligibility requirements

Implementation of the Governor's health policy agenda is the responsibility of the Secretary of the California Health & Human Services (CHHS) Agency, Mark Ghaly, M.D. The Secretary oversees 15 departments, including the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). While CalOptima works closely with DHCS, it is important to understand the larger health care context in California as the state continues to move toward additional integration across public programs to address social determinants of health and complex issues such as homelessness. This will require collaboration with multiple state-level departments, which will impact CalOptima's work.

CHHS' current guiding principles include the following:

1. Adopt a culture of collaboration and innovation.
2. Focus on outcomes and value generation.
3. Use data to drive action.
4. Put the person back in person-centered.
5. See the whole person.[v]

These principles will guide DHCS' work, and CalOptima can use them to think proactively and strategically about likely actions that will be taken over the next several years. Some initiatives are starting to take shape at DHCS and should be factored into CalOptima's next Strategic Plan to ensure necessary resources will be available and that the health plan can be as proactive in its preparations as possible. While DHCS does not have a current strategic plan,[vi] the department has shared priorities that are in line with the CHHS vision to provide a better patient experience with improved outcomes and lower costs.

The following graphic, which may be updated in the next strategic plan, defines the high-level goals of DHCS.[vii] This highlights many of the same themes outlined by CHHS and CMS, including the focus on the member, providing high-quality care, and using public dollars in an effective and efficient manner.

With the rapid growth of the program due to the addition of the Medi-Cal expansion population in 2014, Medi-Cal is the largest Medicaid program in the nation, providing coverage to one-third of all Californians. In more recent years, Medi-Cal enrollment growth has leveled off (and even declined slightly), but the 2019–2020 state budget provision extending Medi-Cal eligibility to undocumented immigrants between the ages of 19–25 is projected to provide full-scope Medi-Cal coverage to an additional 138,000 individuals when it takes effect in 2020.[viii] As discussed above, however, it is possible enrollment will be lower than anticipated due to federal immigration policy.

Currently, DHCS is engaged in several initiatives and pilots that point to its direction to increase person-centered care and to integrate across programs. These include the Coordinated Care Initiative, Whole-Person Care Pilots, Health Homes Program and the Whole-Child Model. CalOptima is currently involved with all these initiatives at some level and has demonstrated a commitment to being innovative and testing new programs that meet the strategic priorities of the state. As these pilots and programs are evaluated and DHCS determines how it will incorporate lessons learned into the broader Medi-Cal program, it is inevitable that there will be some expansion of the programs and some adjustments for the pieces that did not yield expected results. CalOptima is in a strong position to move forward with the state as these projects evolve and to provide input and feedback to DHCS to drive sustainable changes to the Medi-Cal program.

Key Medi-Cal initiatives underway at DHCS that will shape the future direction of the program, and impact CalOptima's work, are discussed below.

Expiration of Federal Section 1115 Medicaid Waiver (Medi-Cal 2020)

The current federal Section 1115 Medicaid waiver expires at the end of 2020. Currently, the entire managed care program (including the authority under which CalOptima operates) is included in the Section 1115 waiver. In addition, the waiver includes authorization for the Whole-Person Care (WPC) pilots, Public Hospital Redesign & Incentives in Medi-Cal (PRIME), the Global Payment Program, Dental Transformation Initiatives, the Drug Medi-Cal Organized Delivery System, California Children's Services (CCS) pilots, and the Coordinated Care Initiative (CCI). The federal government has changed its guidance to states regarding the calculation of "budget neutrality" (all Section 1115 waivers are required to demonstrate they do not cost the federal government more than would otherwise have been spent in the absence of the waiver), which will result in less federal funding for California under a new waiver. This shortfall will drastically reduce the amount of funding available for DHCS to invest

in pilot programs and initiatives and will require the transition of many of the activities under the current waiver into sustainable models, which may involve moving those components into the managed care program. The theme of consolidation, alignment and standardization across the Medi-Cal program is expected to be a significant part of the waiver renewal and is reflected in other activities by DHCS as outlined below. However, because many of these pilot programs, such as WPC, vary significantly in design and target populations by county, standardization will present unique challenges for each county, and DHCS will have to identify the components that will be included statewide.

DHCS California Advancing and Innovating Medi-Cal (CalAIM) Initiative

In 2018, DHCS convened a comprehensive set of stakeholders for its Care Coordination Assessment Project to discuss how to improve Medi-Cal care coordination and developed key themes and next steps from these meetings. [ix] Key findings included the desire to standardize benefits across counties, streamline assessments across programs, and reduce the number of carve-out benefits (such as specialty mental health, dental and long-term care). DHCS has used the recommendations from the Care Coordination Assessment Project to develop its next set of policy initiatives and program changes, including the newly announced CalAIM initiative. CalAIM is a multiyear initiative with the following objectives: "(1) reducing variation and complexity across the delivery system; (2) identifying and managing member risk and need through population health management strategies; and (3) improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform."[x]

Throughout 2019 and 2020, DHCS intends to engage stakeholders to discuss both CalAIM and the renewal of Medi-Cal's federal waivers. DHCS has indicated it will transition all existing managed care authorities into a single, consolidated federal Section 1915(b) waiver that will include the Medi-Cal Managed Care Plans, the County Mental Health Plans, the Drug Medi-Cal Organized Delivery System Plans and the Dental Managed Care Plans. While DHCS has yet to release a detailed CalAIM proposal, it has shared some limited information about the stakeholder workgroups that will be formed to provide input on the development of CalAIM.[xi] Workgroup topics include: (1) Population Health Management and Annual Health Plan Open Enrollment; (2) NCQA Accreditation; (3) Enhanced Care Management and In Lieu of Services; (4) Behavioral Health; and (5) Full Integration Pilots.

DHCS Stakeholder Advisory Committee

The DHCS Stakeholder Advisory Committee (SAC) was originally established to provide input on the development of the federal Section 1115 waiver. However, it has evolved over time to become the body DHCS uses to discuss issues well beyond the federal waiver, including health care reform and state developments more broadly. With the upcoming renewal of the Section 1115 waiver, DHCS has stated it will begin to discuss in October 2019 the specific proposals related to transitioning the Medi-Cal 2020 waiver into a sustainable model.

DHCS Behavioral Health Stakeholder Advisory Committee

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) is a newly formed, stakeholder workgroup focused on the issues related to the delivery of behavioral health services in Medi-Cal. The current system, which is bifurcated between the health plans (which are responsible for delivering mild-to-moderate services) and the counties (which are responsible for specialty mental health services), is under scrutiny and criticism from many stakeholders. DHCS recently received federal approval to extend the current federal Section 1915(b) Specialty Mental Health Services waiver to the end of 2020 to align with renewal of the Section 1115 waiver. As noted above, DHCS intends to submit a single, consolidated federal Section 1915(b) waiver that will include all of the managed care programs across Medi-Cal, including specialty mental health services.

Prescription Drugs Executive Order

On his first day in office, Governor Newsom announced an Executive Order (EO) intended to control rising pharmacy costs.[xii] The EO includes a shift to bulk purchasing for all government programs, including Medi-Cal (the largest purchaser of prescription drugs in the state). This will involve carving out the Medi-Cal pharmacy benefit from the health plans, so the state can negotiate for all its programs collectively, which it anticipates will result in lower costs. Even with concerns from Medi-Cal stakeholders and opposition from health plans, DHCS has been instructed to move forward on a very aggressive timeline and complete the transition by January 2021. DHCS recently released an RFP to select a single vendor to manage the entire pharmacy benefit under a fee-for-service arrangement.[xiii] Despite running counter to other actions designed to integrate services and benefits across the Medi-Cal program, it appears pharmacy will be carved out. Once the shift occurs, the Medi-Cal health plans will need to be prepared to work with the state's pharmacy vendor to access pharmacy data for their members and coordinate care.

DHCS Managed Care Accountability Set

In early 2019, DHCS announced a major change in quality reporting requirements for the Medi-Cal health plans: health plans must report on the complete CMS Core Measures Set for both adults and children (known as the Managed Care Accountability Set in California).[xiv] This represents a significant increase in the number of measures reported and is being implemented for Measurement Year 2019. Additionally, DHCS currently requires that health plans meet a Minimum Performance Level (MPL) of the 25th percentile and will move to a 50th percentile MPL effective for Measurement Year 2019. While negotiations between the health plans and DHCS have helped reduce the administrative burden and potential for sanctions in the first year of the transition, this is a heavy lift for the health plans and DHCS, and another indicator of a new Administration that is determined to make changes and maintain aggressive implementation timelines. With themes of quality and value throughout both the federal and state priorities, it is likely the pressure to demonstrate high-value care will continue to be a growing focus of DHCS.

Future of the Coordinated Care Initiative (CCI)

CCI, which is currently operating in seven counties, includes the mandatory enrollment of dual eligibles into Medi-Cal managed care, implementation of a managed long-term services and supports (MLTSS) benefit, and assumption of risk by the health plans for long-term care placements.[xv] It also includes the Cal MediConnect (CMC) duals demonstration, which has been extended through 2022.[xvi] The CCI has been placed into state law with no sunset date and an expansion of certain elements would be in line with other efforts by DHCS to align and integrate benefits statewide. Notably, DHCS recently announced that, starting in January 2021 (which aligns with the waiver renewal timeline), it will carve in long-term care benefits to all its managed care models, signaling the move toward standardization of benefits across the state.

The CCI program requires federal waiver authority, and the CMC program requires continued federal approval and negotiation of a three-way contract between DHCS, CMS and the health plans. The future and status of this program is less certain and may be resolved as part of the Section 1115 waiver discussions and negotiations.

Medi-Cal Managed Care Rates

DHCS must submit actuarially sound managed care rates to CMS for review and approval. The capitation rates paid to health plans are tied directly to the Medi-Cal benefits included in the health plan contracts. Per federal regulations, 42 CFR Section 438.4 (a) defines actuarially sound capitation rates as *"projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO … for the time period and the population covered under the terms of the contract."* This means that Medi-Cal Managed Care Plan capitation rates only reflect the costs of providing services to populations included in the contract with DHCS.

The complicated rates structure, which has evolved over many years, has led to thousands of individual rate cells that have to be calculated

by DHCS every year. DHCS has been moving to speed up its rate development process, which is currently under almost a two-year delay, to provide more timely rates to health plans and to meet CMS requirements for prospective rate setting. In addition, DHCS has recently indicated it is examining how to move to a regional rate-setting model, which would streamline its work and require significantly fewer rate cells. However, many factors will continue to complicate the rate development process, some of which are outside of DHCS' control. These include directed payments to certain providers, retroactive implementation of benefits, delays in CMS review and approval, and other legislative and administrative activities that impact the Medi-Cal program. As DHCS moves to increase value-based payments and streamline the rate setting process, providing quality data that reflects the cost of providing high-value care will become even more important. Health plans will want to provide input on these transitions to identify downstream and unintended negative consequences and to promote the timely payment of rates.

Encounter Data Reporting

DHCS has continued to put significant pressure on the health plans to provide complete, accurate and timely encounter data. Under federal Medicaid regulations, CMS can withhold federal funds if the state does not submit this data as required. Additionally, the DMHC has initiated an encounter data task force that is charged with working to standardize and improve encounter data reporting across all health plans (Medi-Cal, Commercial, Medicare, etc.). CalOptima will need to be prepared to respond to any future actions that the state takes as it works to enhance encounter data reporting, which is used for both utilization oversight and rate setting purposes. CalOptima should proactively identify where it can improve encounter data collection and be prepared to work collaboratively with its networks and DHCS.

County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. It is important to understand how the federal and state priorities intersect with the local landscape and the needs of the community.

Health Insurance Coverage in Orange County

As shown in the table below, Orange County has more than 30 percent of its population enrolled in public programs, which include Medicare and Medi-Cal, in 2017. [xvii] As the sole Medi-Cal plan in the County, CalOptima has a unique position to impact care delivery and examine ways to reach the additional uninsured. For example, CalOptima offers several plans for individuals with both Medicare and Medi-Cal. Its PACE program for frail seniors has experienced successful growth, in part due to its implementation of the alternative care setting model allowing members to receive services at local Community-Based Adult Services locations. Its OneCare Connect plan, on the other hand, has experienced enrollment and financial performance challenges; the future of this program is uncertain as CMS has approved extension of this program only through 2022.

Current Health Insurance Coverage Type	Statewide	Orange County
Uninsured	7.3%	6.7%
Medicare and Medicaid (Dual Eligibles)	4.3%	3.0%
Medicare	10.9%	11.2%
Medicaid	25.0%	19.1%
Employment-Based	44.4%	51.8%
Privately Purchased	6.5%	7.5%
Other Public	1.5%	0.7%

Competitive Orange County Labor Market

According to the 2019 Orange County Community Indicators Report, the cost of living in Orange County is 91 percent higher than the national average and among the highest in California. The high cost of living is driven largely by high housing costs. In addition, Orange County's unemployment rate (3.0 percent as of June 2019) continues its six-year trend of outperforming state and national unemployment

rates (4.2 percent and 3.8 percent respectively).[xviii] The high cost of living coupled with a low unemployment rate are both challenges for CalOptima. As a public plan, CalOptima has difficulty competing with the private sector for staff in terms of salary. In addition, the low unemployment rate in the County means the hiring environment is very competitive.

Community Collaboration

Community Engagement

CalOptima believes in strengthening its partnerships by enhancing communications with local community organizations and supporting these important partners serving members' health care needs. For fiscal year (FY) 2018–19, CalOptima participated in 126 community events to engage members and the public about CalOptima and its programs, health care and support services. Additionally, CalOptima hosts the quarterly Community Alliances Forum, which is designed to keep CalOptima connected to community stakeholders. CalOptima also participates in more than 30 collaborative meetings throughout Orange County. Finally, CalOptima understands the importance of keeping the local community informed about health plan activities. Through its monthly community announcements and quarterly e-newsletter (known as "Community Connections"), CalOptima provides updates on initiatives and shares information about events and training with more than 2,500 individuals and organizations.

System of Care Data Integration

The County of Orange has launched an integrated data initiative for the County's System of Care for individuals experiencing homelessness. When complete, this initiative will support information sharing across County agencies that offer residents services such as health care, law enforcement, court system, social services and other community resources. Shared data will enhance the coordination of services for "high utilizers" of the County's System of Care and may provide opportunities for early intervention before residents become high utilizers. CalOptima will explore opportunities for data exchange to benefit the mutual individuals we serve.

Behavioral Health/Be Well OC

In 2018, local public and private stakeholders came together to work on behavioral health issues. In addition to CalOptima, key participants include the Orange County Board of Supervisors, Providence St. Joseph Health and Kaiser Permanente. Under this initiative, a regional wellness center is envisioned in Orange County to serve individuals with mental health needs regardless of payor source. The Be Well OC initiative integrates across silos to address social determinants of health and recognizes that issues related to the justice system and housing have a significant impact on health and must be considered as part of a comprehensive solution. This mirrors concerns and priorities highlighted by the state and federal government. CalOptima is well positioned to leverage this local experience to demonstrate its commitment to population health management and effective delivery system transformation.

Homelessness

In Orange County, as across the state, the homeless population has increased significantly over the past few years because of increased housing costs and stagnant wages. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health, health care, housing, community corrections and public social services.[xix] The County's WPC pilot is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing enhanced funding for homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care – As part of WPC, services provide post-acute care for up to a 90-day stay for homeless CalOptima members.
- Medical Respite Care – As an extension to the recuperative care program, CalOptima provides additional respite care beyond 90 days of recuperative care under WPC.

- Clinical Field Teams – In collaboration with community health centers, Orange County Health Care Agency's Outreach and Engagement team and other agencies, the pilot program provides immediate treatment/urgent care to individuals experiencing homelessness.
- Homeless Clinic Access Program – The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County shelters.
- Hospital Discharge Process for Members Experiencing Homelessness – Support is designed to assist hospitals with the increased cost associated with discharge planning under the new state legislative requirements.

As noted above, addressing homelessness is one of the Governor's priorities, and CalOptima can expect the state will be looking for innovative partners to combat this public health crisis.

Health Homes Program (HHP)

HHP is one of the initiatives DHCS has implemented to increase person-centered care and to integrate across programs. CalOptima has elected to bring this program to Orange County to provide increased coordinated care for its highest-risk Medi-Cal members. Eligible members choosing to participate will receive high-touch services, such as in-person health needs assessment, accompaniment to key medical appointments, and housing navigation and sustainability services.

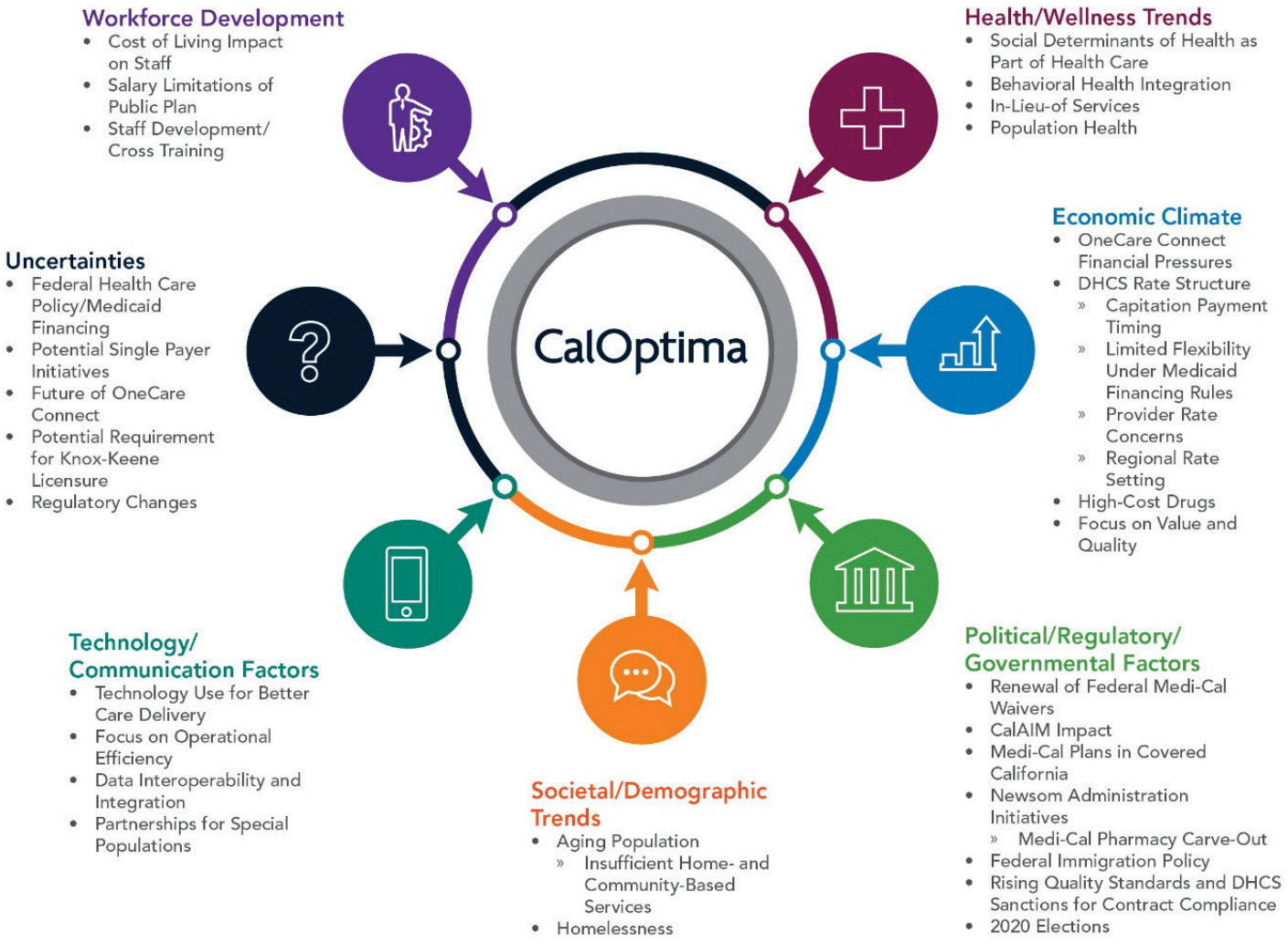
Whole-Person Care Pilot (WPC) Transition to CalOptima

The WPC pilot is expected to transition to the Medi-Cal managed care plans when the waiver expires at the end of 2020. The Orange County Health Care Agency is the lead entity for WP;, and CalOptima has a limited role by providing personal care coordinator services, and access to covered Medi-Cal benefits and funding towards WPC recuperative care. Because details are limited at this time, and it is unclear how DHCS may restructure the individual pilot programs as they transition into managed care, CalOptima will have to be prepared to work collaboratively with WPC stakeholders once DHCS releases more detailed guidance and timeframes. HHP implementation will provide a foundation for this transition.

CalOptima Health Networks and Access

Across California, there are concerns about access to care, the rising cost of living, and a lack of physicians and other health workers. These issues are particularly acute in the Medi-Cal program, which recently launched a physician loan forgiveness program to encourage new physicians to serve this population. CalOptima is engaged in an assessment of its health network structure and reimbursement arrangements to develop stronger networks with value-based payment arrangements. The delivery system study, being conducted by Pacific Health Consulting Group, is expected to be finalized in early 2020 and will present options for CalOptima and its contracted health networks to consider. It is increasingly challenging to recruit and maintain providers with the low reimbursement rates and significant administrative workload associated with the Medi-Cal program (e.g., all providers must now enroll with DHCS). Continued investment in its health networks and collaboration with providers will allow CalOptima to be innovative and meet the needs of members.

Environmental Considerations



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