



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

**THURSDAY, FEBRUARY 13, 2020
8:00 A.M.**

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

AGENDA

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

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

I. CALL TO ORDER

Pledge of Allegiance

II. ESTABLISH QUORUM

III. APPROVE MINUTES

A. Approve Minutes of the December 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

IV. PUBLIC COMMENT

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

V. REPORTS

- A. Consider Recommendation of Agency-Appointed Representative from the Orange County Health Care Agency (OCHCA)

VI. MANAGEMENT REPORTS

- A. [Chief Executive Officer Update](#)
- B. Chief Operating Officer Update
- C. Chief Medical Officer Update

VI. INFORMATION ITEMS

- A. [Trauma Informed Care and Proposition 56 \(Tobacco Tax\) ACE Screening](#)
- B. Health Homes Program Update
- C. [Behavioral Health Update](#)
- D. Intergovernmental Transfer (IGT) 9 Update
- E. Optometry Scope of Practice Expansion
- F. [Medi-Cal Healthier California for All Update](#)
- G. [Provider Advisory Committee Member Updates](#)

VII. COMMITTEE MEMBER COMMENTS

VIII. ADJOURNMENT

MINUTES

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

December 12, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 12, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:06 a.m. Teri Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Jena Jensen; John Kelly, M.D.; Junie Lazo-Pearson, Ph.D.; Craig Myers; Jacob Sweidan, M.D.; Tina Bloomer, MHNP; Loc Tran, PharmD.; Pat Patton, MSN

Members Absent: All Members present

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Betsy Ha, Executive Director, Quality and Population Health Population Management, Tracy Hitzeman, Executive Director, Clinical Operations; Shamiq Hussain, Sr. Policy Advisor, Government/Legislative Affairs; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant

MINUTES

Approve the Minutes of the October 10, 2019 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and the Whole-Child Model Family Advisory Committee

Action: On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the October 10, 2019 Special Joint meeting. (Motion carried 12-0-0)

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

Action: On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the November 14, 2019 Regular meeting. (Motion carried 12-0-0)

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS

Consider Recommendation to Reclassify Provider Advisory Committee Seats

The PAC Recruitment Ad Hoc Committee comprised of Chair Nishimoto, Vice Chair Miranti and Member Lazo-Pearson recommended that the vacant Long-Term Services and Supports Representative seat be reclassified as an additional Allied Health Services seat. The Committee also recommended renaming the Traditional/Safety Net seat to Safety Net Representative seat.

Action: On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation to reclassify the PAC Committee seats. (Motion carried 12-0-0)

Consider Recommendation to Revise Provider Advisory Committee Chair and Vice Chair Term Lengths

The Joint Advisory Recruitment Ad Hoc Committee which consists of the Chairs and Vice Chairs of the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC) and PAC, recommended that the Chair and Vice Chair term lengths be changed from a one year term to a two-year term for all committees.

Action: On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation to revise the PAC Chair and Vice Chair Term Lengths (Motion carried 12-0-0)

Chair Nishimoto reordered the agenda to hear item VI.A Delivery System Update before continuing with the Chief Executive Officer Report.

Delivery System Update

Tim Reilly, Partner, Pacific Health Consulting Group (PHCG) presented an update on the progress of PHCG's review of CalOptima's Delivery System. Mr. Reilly noted that the final report will be presented at the February 6, 2020 CalOptima Board meeting.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer (CEO), provided an update on the CalAIM Program. Mr. Schrader also updated the members on the Department of Health Care Services (DHCS) Managed Care Plans (MCP) state waiver proposal for FY 2021-2025.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), provided an update on the Behavioral Health Integration between CalOptima and Magellan effective January 1, 2020. Ms. Khamseh also reported that phase one of the Health Homes Program (HHP) would also become effective January 1, 2020.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), discussed CalOptima's incentives for Skilled Nursing Facilities (SNFs). Dr. Ramirez also provided an update to the Medication Assisted Therapy program's (MAT) pharmacy waiver.

INFORMATION ITEMS

Homeless Health Update

Mary Botts, Manager, Enterprise Analytics provided a presentation on the Homeless Health Clinical Analysis. Ms. Botts discussed the homeless identification methods and provided a comprehensive analysis of the homeless population trend and identified disparities. Ms. Botts also noted that CalOptima has partnered with the Orange County Health Care Agency and several other healthcare entities.

Proposition 56 Tobacco Tax Update

Candice Gomez, Executive Director, Program Implementation, discussed the Proposition 56 (Tobacco Tax) initiatives. Ms. Gomez mentioned the Adverse Childhood Event (Trauma) Screening Services that will become effective July 1, 2020. She also noted the Behavioral Health Integration Incentive Program's application reviewing deadlines conducted by DHCS. The first application for the BHI Incentive Program for Managed Care Plans will be due January 21, 2020.

Federal & State Budget Update

Shamiq Hussain, Sr. Policy Advisor, Government Affairs, provided a brief update on the California state budget. Mr. Hussain noted that the DHCS policy discussion is centered around the CalAIM proposals, which may evolve as DHCS receives stakeholder feedback and input from the Centers for Medicare & Medicaid Services (CMS),

PAC Member Updates

Dr. Nishimoto noted he would be presenting at the next PAC Meeting which is scheduled for February 13, 2020 at 8:00 a.m.

ADJOURNMENT

There being no further business, Chair Nishimoto adjourned the meeting at 10:01 a.m.

/s/ Cheryl Simmons

Cheryl Simmons

Staff to the Advisory Committees

Approved: February 13, 2020

MEMORANDUM

DATE: January 28, 2020
TO: CalOptima Board of Directors
FROM: Michael Schrader, CEO
SUBJECT: CEO Report — February 6, 2020, Board of Directors Meeting
COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

January 2020 Brings Two Program Launches, Restoration of Medi-Cal Benefits

As the new decade rang in, two CalOptima programs designed to enhance services and care coordination for members began and a variety of Medi-Cal benefits were restored.

- *Health Homes Program (HHP):* Phase 1 of CalOptima’s HHP went live January 1 for members with eligible chronic conditions and substance use disorders. Raising awareness about the voluntary program is an ongoing priority, and CalOptima and our health networks are reaching out to eligible members with information about the program and enrollment details. HHP benefits range from comprehensive care management and care transitions support to housing navigation services and accompaniment to doctor visits. Data show that approximately 7,000 members may be eligible to participate in the first phase. A second phase is planned for July 2020.
- *Behavioral Health:* Administration of behavioral health benefits for OneCare and OneCare Connect (OCC) members has transitioned from Magellan Healthcare to CalOptima. Members in need of services for mild to moderate mental health conditions will now work with CalOptima directly. The January 1 change went smoothly, as CalOptima took over utilization management of members with active services and began responding to incoming calls. The transition allows for a more coordinated approach to physical and mental health.
- *Restored Medi-Cal Benefits:* California has reinstated several Medi-Cal benefits that were cut in 2009 due to the recession. Effective January 1, adult members are now covered for eyeglasses, podiatry, audiology, speech therapy, and incontinence creams and washes. The FY 2019–20 state budget includes more than \$17 million for the benefits.

California Advancing and Innovating Medi-Cal (CalAIM) Changed to Medi-Cal Healthier California for All; Stakeholder Engagement Continues

Effective January 8, Gov. Gavin Newsom and the Department of Health Care Services (DHCS) renamed CalAIM to Medi-Cal Healthier California for All. The change was made to highlight the well-known Medi-Cal name and better align the initiative with the governor’s platform to build a “California for All,” according to a press release. The effort to gather stakeholder feedback about the many proposals is ongoing. As I have shared in prior reports, CalOptima is focused on those initiatives that have the most potential to immediately impact our agency, especially enhanced care management and in lieu of services. In fact, managed care plans must provide a transition plan by July 2020 that addresses how Whole-Person Care and HHP will move to enhanced care management and in lieu of services, effective January 2021. CalOptima is looking forward to a February 10 meeting with DHCS to learn more about the proposed

transition. Given the significance of the changes under consideration, I will continue to share regular updates about Medi-Cal Healthier California for All with your Board.

State Budget Proposal Offers a Glimpse at FY 2020–21 Priorities

On January 10, Gov. Newsom released his proposed budget for FY 2020–21. Overall, the budget anticipates that the California economy will continue to grow (albeit at a slower rate than previous years) and proposes a total state budget of \$222.2 billion, with a surplus of more than \$5 billion. Some of the surplus will support the governor’s policy priorities, including expanding access to Medi-Cal for undocumented seniors age 65 and older, and addressing the state’s homelessness crisis. To that end, the budget proposes \$750 million to establish the California Access to Housing and Services Fund, which would be dedicated to moving individuals and families into stable housing. The governor is also pursuing an ambitious agenda to transform the Medi-Cal delivery system through the newly renamed Medi-Cal Healthier California for All package of proposals, which received a \$695 million allocation. Another major piece of the governor’s health plan is reducing prescription drug costs. This past year, his emphasis was on bulk purchasing of prescription drugs by carving out pharmacy from Medi-Cal managed care. This year, he proposes that the state negotiate partnerships with generic drug manufacturers to establish California’s own generic drug label. The May Revision is the next step in California’s budget process, and staff are monitoring its development.

Organizations Respond to Behavioral Health Integration (BHI) Incentive Opportunity

Aiming to improve health outcomes, DHCS created six BHI incentive programs using Proposition 56 funds and tasked Medi-Cal managed care plans with administering the application process and applying DHCS-developed selection criteria. CalOptima received 30 BHI incentive program applications from 15 organizations seeking nearly \$10 million.

BHI Incentive Program	Number of Applications	Dollars Requested
Basic behavioral health integration	13	\$6,974,676
Maternal access to mental health and substance use disorder screening and treatment	1	\$200,000
Medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses	4	\$710,000
Diabetes screening and treatment for people with serious mental illness	5	\$740,160
Improving follow-up after hospitalization for mental illness	4	\$755,000
Improving follow-up after emergency department visit for behavioral health diagnosis	3	\$530,000
TOTALS	30	\$9,909,836

CalOptima is required to review and score applicants, subject to DHCS criteria and approval, as well as distribute funding and monitor the programs. CalOptima formed an evaluation committee of internal and external reviewers, and the group met in late January for training on the state’s scoring criteria and timeline. Reviews are due to DHCS by February 18, and CalOptima will issue participation decisions by March 18. Programs are then expected to go live on April 1 and continue until December 31, 2022.

CalOptima Submits Medicaid Fiscal Accountability Rule (MFAR) Comment Letter

In my December 2019 CEO Report, I shared the growing concern about MFAR's impact on Medi-Cal financing. At the recommendation of our advocates, CalOptima submitted formal comments to complement the efforts of DHCS and our state and federal trade associations. MFAR's proposed constraints on generating additional funding through public hospital financing, the Managed Care Organization tax, and supplemental payments, such as Intergovernmental Transfers, could leave a large hole in California's budget that was previously filled by federal matching dollars.

Supreme Court Permits Public Charge Rule, Potentially Affecting Medicaid Enrollment

On January 27, in a 5–4 decision, the Supreme Court ruled to allow the Trump Administration to implement the Public Charge Final Rule with an expanded means test for immigrants seeking naturalization. The rule expands how the federal government interprets and determines “public charge” to include immigrants who access cash public benefits, such as welfare, but also non-cash public benefits, including Medicaid (Medi-Cal in California). The rule makes it more difficult for immigrants to obtain permanent residency if they have used or are likely to use public benefits. Observers believe the rule will discourage immigrants from seeking health care coverage or cause them to drop their existing coverage, lest they compromise their naturalization status. The Supreme Court lifted a stay that had blocked implementation until a lawsuit against the rule was settled. The lawsuit is still pending.

California Children's Services (CCS) Advisory Group to Gather Post-Transition Data

The January 22 quarterly meeting of the CCS Advisory Group focused on upcoming efforts to capture family feedback about the Whole-Child Model (WCM) and establish health plan performance measures.

- *Telephone Survey:* UC San Francisco has been engaged to conduct a telephone survey of parents of CCS children in WCM and non-WCM counties. The goal is to assess participant satisfaction, experiences with care, and perceived changes in access, quality and care coordination since the WCM transition. UCSF is in the process of finalizing the survey, which will be administered from April to June. The target sample size is 3,000 respondents. Preliminary findings are not expected until December 2020.
- *Dashboard Template:* The state released a sample WCM Performance Dashboard for stakeholder review and comment. It is designed to collect data about health plans' WCM programs. Some of the suggested measures include enrollment figures, emergency room visits, inpatient admissions, prescription use, mental health services, NICU authorizations, and grievances and appeals. The timeframe for publishing the dashboard was not announced. The group was supportive of the dashboard and asked that it include data from not only the five WCM plans but also from the counties that have not transitioned to WCM.

Annual State Audit Underway, Reviewing Medi-Cal and OCC

On January 27, DHCS began its annual medical audit of Medi-Cal and OCC (Medicaid-based services only). Auditors are expected to be on site until February 7, studying CalOptima's compliance with contractual and regulatory requirements in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity, for the review period of February 1, 2019, to January 31, 2020.

OCC Event Draws Current and Prospective Members

On Saturday morning, January 25, CalOptima welcomed more than 60 prospective and current members to our third OCC Member Retention/Outreach Event at the Garden Grove Community Center. The event included a presentation about the 2020 OCC program and benefits, which was followed by a Q&A session with internal subject matter experts from our Customer Service and Pharmacy departments as well as external experts from Community Legal Aid SoCal, Vision Service Plan and Denti-Cal. In addition, members had an opportunity to visit 16 resource tables, which featured contracted health networks, vendors, CalOptima departments and community-based organizations.

CalOptima Names Sharon Dwiars Clerk of the Board

After serving in an interim capacity, Sharon Dwiars has been named Clerk of the Board. Ms. Dwiars assists the Board and Board committee chairs in conducting public meetings and serves as the custodian of official agency records for public and government use. She has been with CalOptima for more than 23 years.



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Trauma-Informed Care and Adverse Childhood Experiences Screening

**Provider Advisory Committee
Member Advisory Committee
February 13, 2020**

**Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management**

Adverse Childhood Experiences (ACEs)

*“ACEs and toxic stress
represent a
public health crisis.”*



*Dr. Nadine Burke Harris
California Surgeon General*

Agenda

- Beyond Prop 56 Directed Payments for ACEs Screening Services
- Impact of Trauma on Health
- Evidence-Based Studies of ACEs
- Population Health Impact
- Trauma Informed Care
- ACEs Aware Request For Proposal Update
- Questions

Prop 56: Adverse Childhood Experiences (ACEs) Screening

- California's first Surgeon General is advocating universal ACEs screening for Medi-Cal as a public health crisis
- Prop 56 directed payment for ACEs Screening effective 1/1/2020
 - Tool for kids: Pediatric ACEs Screening and Related Life-events Screener (PEARLS)
 - Tool for adults: ACEs
 - Healthcare Common Procedure Coding System (HCPCS) code G9919 for positive screening and provision of recommendations (score of 4 or greater)
 - HCPCS code G9920 for negative screening
 - Minimum directed payment \$29 per ACEs screening performed
- Screenings should be completed by a Medi-Cal enrolled provider

Defining Trauma



Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

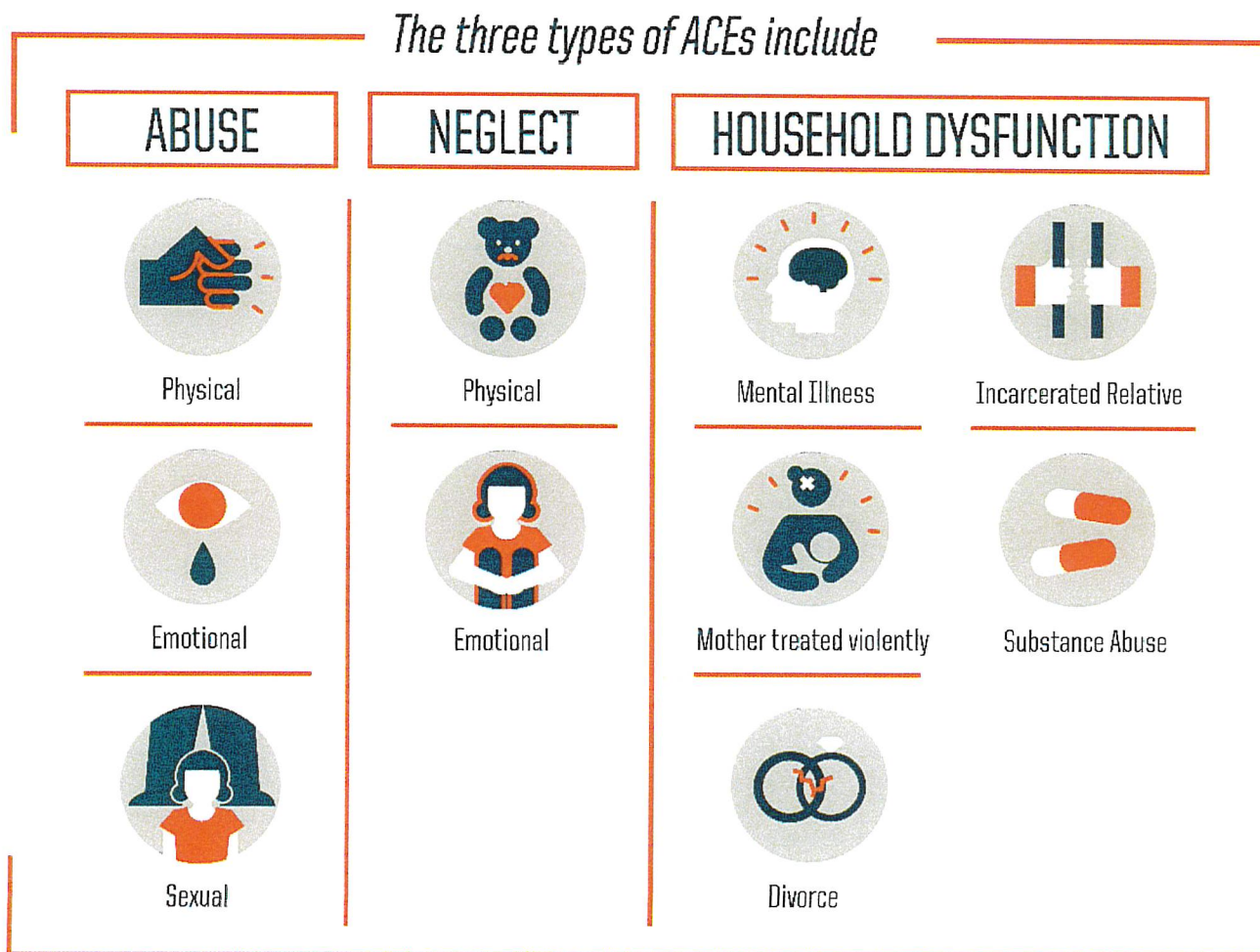
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Defining Trauma

- **Adverse Childhood Experiences (ACEs)** are stressful or traumatic events, including abuse, neglect, and household dysfunction, that occur during childhood.
- **Toxic Stress** is a stress response that occurs when a person experiences strong, frequent, and/or prolonged adversity without adequate support.



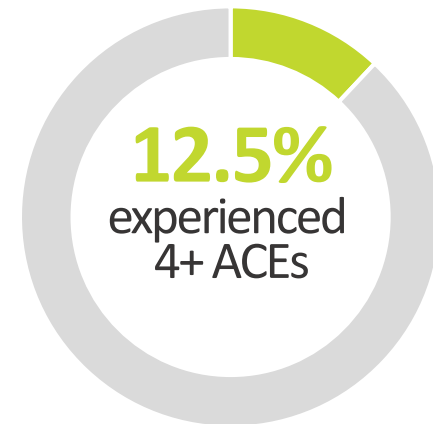
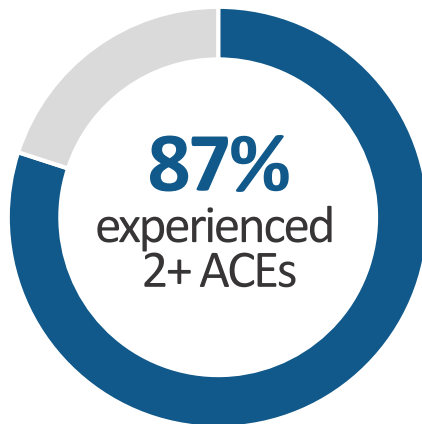
Adverse Childhood Experiences



Landmark Adverse Childhood Experiences Study



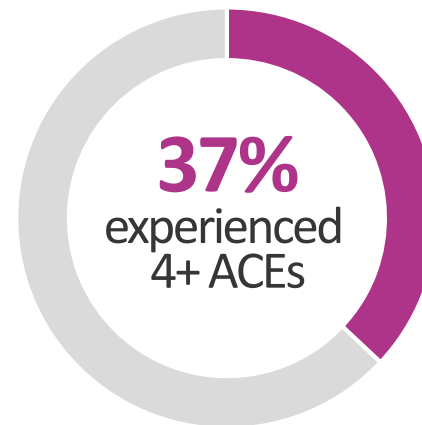
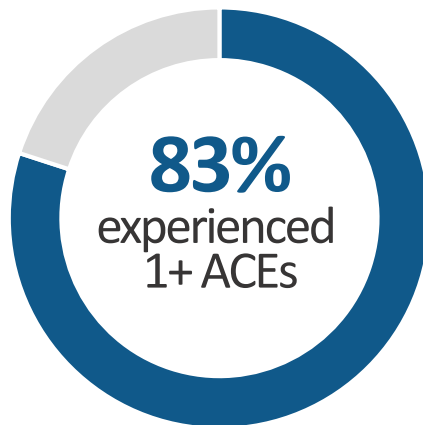
- In 1998, more than 17,000 Kaiser Permanente members took the Adverse Childhood Experiences (ACE) Survey.
- **Results:** Two-thirds of respondents had experienced one or more types of ACEs. Of those:



Prevalence of Trauma: Philadelphia Urban ACE Study



- In 2012 a racially diverse sample of men and women in Philadelphia took a questionnaire that was based on the original ACEs Survey. Respondents were mostly between the ages of 35 to 64 and had completed high school.
- **Results:** More than four out of five respondents experienced at least one ACE:



Impact of Trauma: Health, Behavior, and Life Potential

- ACEs can have lasting effects on...



Health - obesity, diabetes, depression, suicide attempts, STIs, heart disease, cancer, stroke, COPD, broken bones

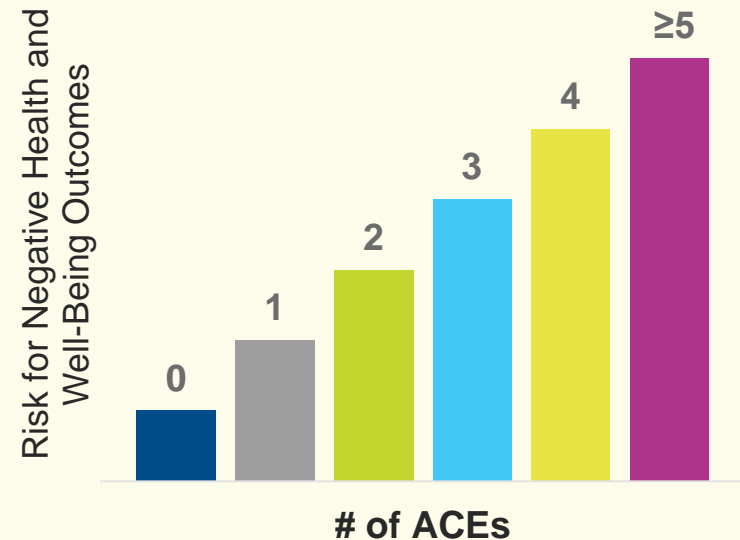


Behaviors - smoking, alcoholism, drug use



Life potential - graduation rates, academic achievement, lost time from work

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.



*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcomes.

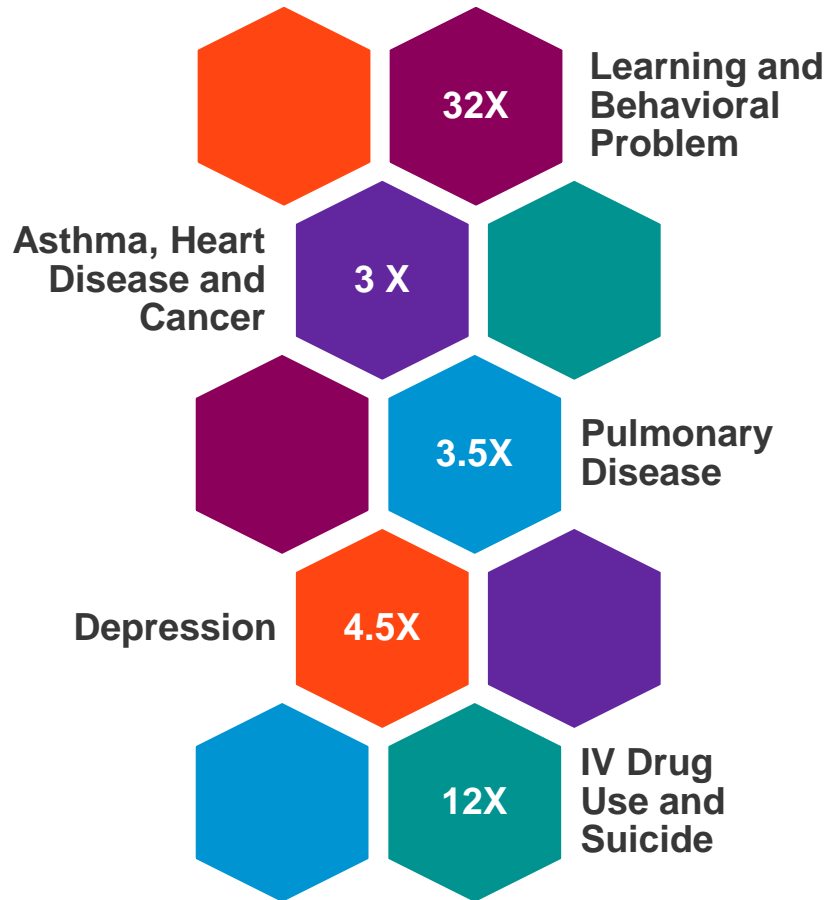
Impact of Trauma: ACEs and Neurobiology



- Traumatic experiences in childhood and adulthood invoke *flight, fight, or freeze* responses
- Responses become toxic when turned on for too long (constant flood of adrenaline and cortisol)
- Prefrontal cortex development may become stunted
- Traumatic experiences can cause people to see the world as a place of constant danger — resulting in fear, anxiety, depression, anger, etc.
- Find solace in alcohol, tobacco, drugs, food, high-risk behaviors, etc.

Population Health Impact

- Children who experience 4 or more ACEs:



**7 out of 10
leading causes
of death in the
U.S. adults
correlate with
exposure to ≥ 4
ACEs**

Source: CDC-Kaiser Permanente ACEs Study, 1995-97

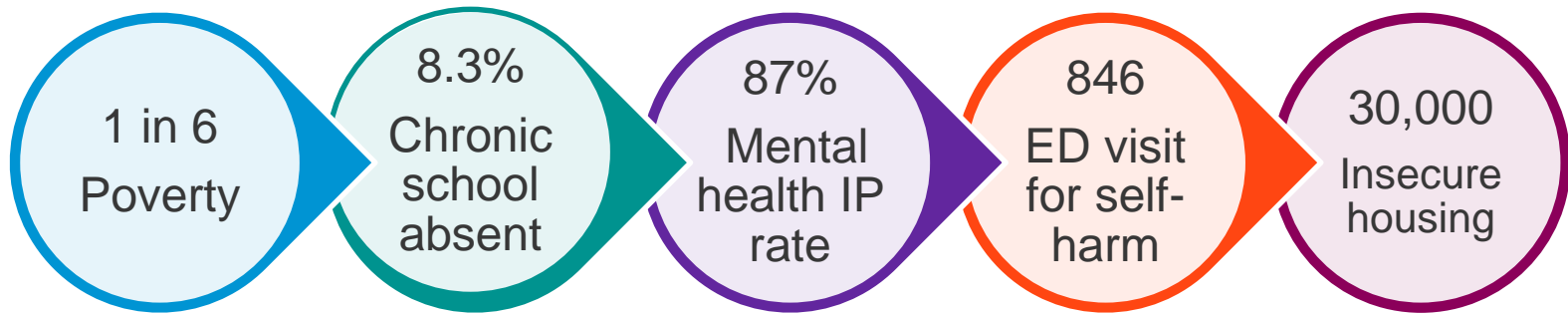
Adult Health Burden and Cost in California

Center for Youth Wellness released on January 28, 2020:

- Previous studies on child abuse and neglect have estimated the lifetime cost to the United States to be approximately \$124 billion annually.
- This new study found the health-related costs of ACEs to California alone were approximately \$113 billion a year.
- Estimate includes:
 - \$10.5 billion ACEs-related health care costs
 - \$102 billion in the cost of disease burden (e.g. premature death, and years of productive life lost to disability)

Citation: Miller TR, Waehrer GM, Oh DL, Purewal Boparai S, Ohlsson Walker S, Silverio Marques S, et al. (2020) Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences. PLoS ONE 15(1): e0228019. <https://doi.org/10.1371/journal.pone.0228019>

Condition of Children in OC



Source: 25th Annual Report on the Condition of Children in Orange County

Condition of CalOptima Children

CalOptima has approximately 279,000 children between the ages of 0–18 years.

- 1% (1,800) of these children are homeless
 - Over 90% of the children were identified through the homeless source of “address”
 - 9% of the homeless high confidence population
- Emergency Department Rates
 - Overall trends are slightly higher, but rates for ED visits related to diagnosis of suicidal ideation, self-harm or attempted suicide were low
- Social Determinants (Based on ICD-10 Codes)

Housing and Economics	Psychosocial	Social Environment	Support and Family	Upbringing
363	449	106	996	1,114

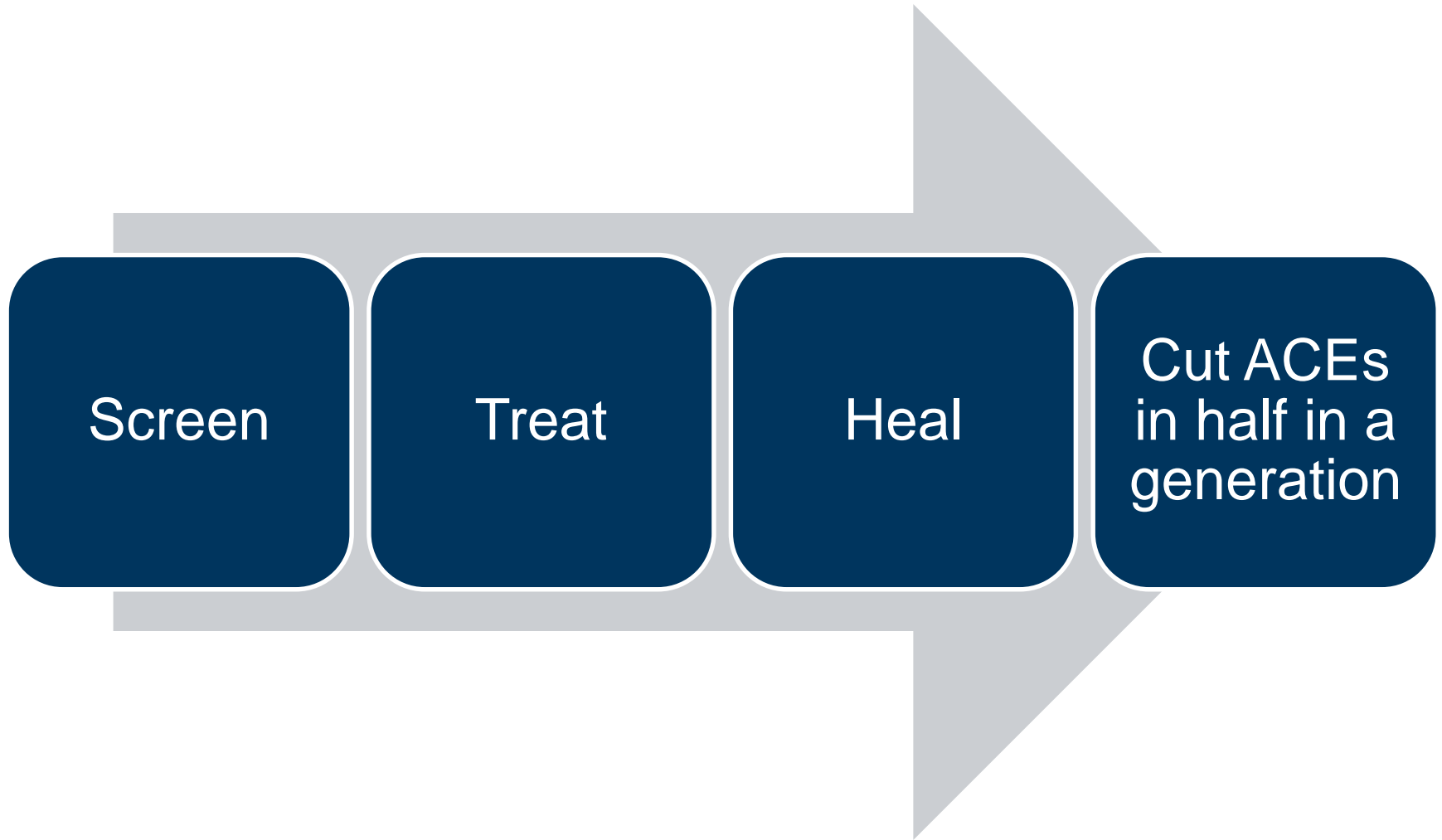
Population Segments at Risk for ACE

Age	Membership	ACE Tool	Estimated membership with >4+ ACE
0–5	82,406	PEARLS	30,000
6–18	216,029	PEARLS	80,000
19–40	192,494	ACE	71,000
41–64	158,892	ACE	58,000
65+	90,801	ACE	<u>34,000</u>
			Total: 273,000

Legend:

1. Based on 2019 Medi-Cal Membership
2. >4 ACES prevalence based on the findings from the Philadelphia Urban ACE Survey; 37% experienced 4 or more ACE, Robert Wood Johnson Foundation. September 2013.
3. PEARLS: Pediatric ACES and Related Life Events Screener, ACE tool for children

ACEs Aware Initiative



ACEs Aware RFP

- California–Office of the Surgeon General (CA-OSG) and the Department of Health Care Services (DHCS) fund organization to help extend and reach Medi-Cal providers and organizations that serve Medi-Cal beneficiaries through the following grant opportunities:
 - Provider Training
 - Certification of Existing Training Curricula
 - Training activities
 - Provider Engagement
 - Communication
 - Convenings
- CalOptima supporting two lead organizations' RFP targeting provider serving children and adult population

Solution: Trauma-Informed Care Framework

Understanding

- The prevalence and impact of trauma and adversity on health and behavior

Recognizing

- The effects of trauma and adversity on health and behavior

Responding

- By incorporating trauma-informed principles throughout clinical practices and community support systems

Integrating

- Knowledge about trauma and adversity into policies, procedures, practices, and treatment planning

Resisting

- Re-traumatizing, including staff

Other Clinical Responses to ACEs

- Treat ACEs related health conditions by supplementing usual care with health education of toxic stress and regulate stress responses:
 - Safety and supportive relationship
 - Regular exercises
 - Good sleep
 - Healthy nutrition
 - Mindfulness practice
- Validate existing strengths
- Referral to resources or interventions, including care coordination, patient navigation, community health workers, community resources, social work, and/or mental health care as necessary

Systems for Building Resilience



Source: Centers for Disease Control and Prevention, "About the ACEs Study"
<https://www.cdc.gov/violenceprevention/acestudy/about.html>

What is Trauma-Informed Care?

What is Trauma-Informed Care?

<https://youtu.be/fWken5DsJcw>



<https://www.acesaware.org>

Questions



CalOptima's Mission

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



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Medi-Cal
CalOptima
Better. Together.



OneCare (HMO SNP)
CalOptima
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OneCare Connect
CalOptima
Better. Together.



PACE
CalOptima
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Behavioral Health (BH) Transition Update

Edwin Poon, Ph.D.

Director, Behavioral Health (Integration)



BH Transition

- In May 2019, the Board of Directors approved transitioning OneCare and OneCare Connect BH services from Magellan to CalOptima
- Multiple departments were involved in the implementation
 - Contracting
 - Provider Relations
 - Claims
 - Customer Service
 - Behavioral Health Integration
 - Information Services
 - Utilization Management
 - Regulatory Affairs and Compliance
 - Process Excellence
- Effective January 1, 2020, CalOptima manages BH services for all lines of business

CalOptima BH Benefits

Mental Health Services	Medi-Cal	OC/OCC
Outpatient psychotherapy	✓	✓
Psychological testing	✓	✓
Medication management	✓	✓
Behavioral Health Treatment*	✓	N/A
Inpatient mental health care	County	✓
Partial hospitalization program	County	✓

**For members under 21 years of age*

CalOptima BH Benefits (cont.)

Substance Use Disorder (SUD) Services	Medi-Cal	OC/OCC
Alcohol misuse screening and counseling	✓	✓
Office-based Medication Assisted Treatment (MAT)	✓	✓
Opioid Treatment Program (OTP)	Drug Medi-Cal Organized Delivery System	✓
Medical detox	✓	✓
All other SUD services (e.g., residential treatment, recovery services and withdrawal management)	Drug Medi-Cal Organized Delivery System	Drug Medi-Cal Organized Delivery System

BHI Department Restructure

- Integration

- BH initiatives (Quality, Utilization Management, Regulatory, etc.)
- Community partnerships
- Regulatory (DHCS and CMS audits, NCQA, policies, etc.)
- Internal departments support

- Clinical Operations

- BH call center
- Care management
 - Behavioral Health (Individual Care Team meetings, transitions of care, and BH utilization management/concurrent review)
 - Behavioral Health Treatment (ABA)

CalOptima BH Line

855-877-3885

For screening and referral to mental health services.
This number is available 24 hours a day, 7 days a week.

TTY/TDD: 800-735-2929

Thank You

- BHI would like to thank everyone who supported the implementation process for the past two years
- We could not have done it without your hard work and dedication!





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Medi-Cal Healthier California for All - Update

February 2020

**Candice Gomez, Executive Director, Program Implementation
Pallavi Patel, Director, Business Integration/Process Excellence**

Background

- On October 28, the Department of Health Care Services (DHCS) released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future of the Medi-Cal delivery system framework.
 - Spans a five-year period from 2021 to 2026
 - Contains numerous core initiatives
 - Expands Medi-Cal managed care plans' responsibilities
- Beginning January 8, 2020, DHCS started referring to CalAIM as “Medi-Cal Healthier California for All.”

Medi-Cal Healthier California for All - Goals

- Identify and manage member risk and need through whole-person care approaches and address social determinants of health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

DHCS Timeline

2019

- *October 28, 2019:* DHCS releases Medi-Cal Healthier California for All proposal
- *November 5, 2019:* DHCS begins stakeholder meetings

2020

- *July 1, 2020:* CalOptima submits plan to DHCS describing the transition of WPC and HHP into ECM and ILOS
- *December 31, 2020:* WPC and HHP sunsets

2021

- *January 1, 2021:* Plan incentives, blended LTC/SPD rate, ECM and ILOS begin

2022

- *January 1, 2022:* PHM begins, Full integration plans move forward with an RFP (1/1/22), selection (7/1/22) and 18-month readiness assessment (7/1/22–12/31/23)

WPC = Whole-Person Care
HHP = Health Homes Program
ECM = Enhanced Care Management
ILOS = In Lieu of Services

LTC = Long-Term Care
SPD = Seniors and Persons With Disabilities
PHM = Population Health Management

DHCS Timeline (cont.)

2023

- *January 1, 2023:* CMC plans transition to D-SNPs and mandatory managed care enrollment for dual eligible members begins
- *January 1, 2023:* DHCS implements regional rates
- *January 1, 2023:* ECM model of care for re-entry population is due to DHCS

2024

- *January 1, 2024:* Full integration plans go live

2025

- *January 1, 2025:* NCQA accreditation of managed care plans and delegated entities begins

2026

- *January 1, 2026:* LTSS, LTC and D-SNPs are implemented statewide

CMC = Cal MediConnect
D-SNPs = Dual Eligible Special Needs Plans
LTSS = Long-Term Services and Supports

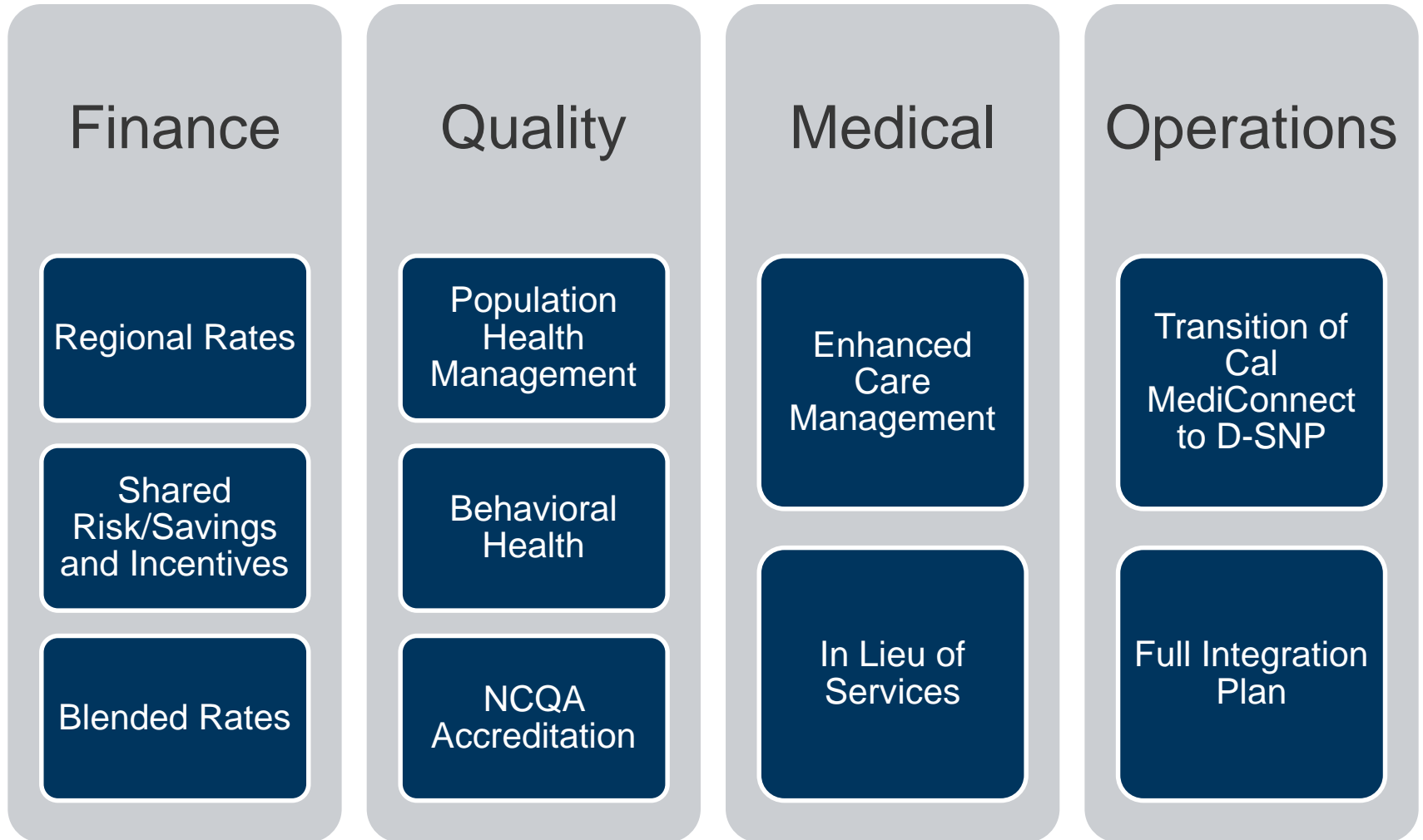
Proposals With Direct Impact

Proposals	Implementation Date
Population Health Management Program	January 2021
Enhanced Care Management Benefit	January 2021
In Lieu of Services	January 2021
Regional Managed Care Capitation Rates	January 2023
Shared Risk/Savings and Incentive Payments	January 2021
Full Integration Plans*	January 2024
NCQA Accreditation**	January 2025
Discontinue Cal MediConnect and transition to D-SNPs	January 2023

* Current status: Behavioral health partially integrated; dental services not integrated

**NCQA accreditation for health networks is new; may have new requirements for managed care plans

Internal Work Efforts



Transition Plan

- DHCS expects CalOptima and all managed care plans to submit a transition plan demonstrating:
 - How elements of existing programs, such as HHP and WPC, will be integrated into the new ECM and ILOS programs
 - A good faith effort to come to agreement with local government agency providers that are rendering HHP and/or WPC services

Upcoming Activities

Date	Milestone
February	Participate in DHCS stakeholder meetings; provide general updates to advisory committees
March	Continue DHCS stakeholder meeting participation; prepare draft transition plan
April	Vet transition plan strategy with Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee
May	Vet transition plan strategy with Quality Assurance Committee and Finance and Audit Committee
June	Seek transition plan approval from Board of Directors
July 1	Submit transition plan to DHCS

CalOptima's Mission

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



2019–20 Legislative Tracking Matrix

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	Medicare Hearing Act of 2019: Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	10/17/2019 Passed the Committee on Energy and Commerce 10/17/2019 Introduced	CalOptima: Watch
H.R. 4650 Kelly	Medicare Dental Act of 2019: Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	10/17/2019 Passed the Committee on Energy and Commerce 10/11/2019 Introduced	CalOptima: Watch
H.R. 4665 Schrier	Medicare Vision Act of 2019: No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	10/17/2019 Passed the Committee on Energy and Commerce 10/11/2019 Introduced	CalOptima: Watch

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 385 Calderon	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Performance Outcome System: Would require the Department of Health Care Service (DHCS) to improve existing performance outcome systems measuring the outcomes of EPSDT services.	05/16/2019 Committee on Appropriations; Held under submission 04/24/2019 Passed Committee on Health 02/05/2019 Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	Medi-Cal Eligibility Expansion: Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately \$900 million General Fund (GF) in 2019-2020 and \$3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services (IHSS).	07/02/2019 Hearing canceled at the request of the author 06/06/2019 Referred to Senate Committee on Health 05/28/2019 Passed Assembly floor 12/03/2018 Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	Women, Infants, and Children (WIC) to Medi-Cal Express Lane: Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program (CHIP), is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	08/30/2019 Senate Committee on Appropriations; Held under submission 06/27/2019 Passed Senate Committee on Health 05/23/2019 Passed Assembly floor 02/13/2019 Introduced	CalOptima: Watch
AB 683 Carrillo	Adjusting the Assets Test for Medi-Cal Eligibility: Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	05/16/2019 Committee on Appropriations; Hearing postponed at the request of the Committee 04/02/2019 Passed Committee on Health 02/15/2019 Introduced	CalOptima: Watch
SB 29 Durazo	Medi-Cal Eligibility Expansion: Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately \$134 million each year (\$100 million General Fund, \$21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services (IHSS) is estimated to cost \$13 million General Fund.	09/13/2019 Held in Assembly 05/29/2019 Passed Senate floor 12/03/2018 Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
<p>H.R. 1978 Correa/Lieu</p>	<p>Fighting Homelessness Through Services and Housing Act: Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of \$750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of \$100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to \$25 million each year for up to five years.</p> <p>Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.</p>	<p>03/28/2019 Introduced; Referred to the House Committee on Financial Services</p>	<p>CalOptima: Watch</p>
<p>S. 923 Feinstein</p>	<p>Fighting Homelessness Through Services and Housing Act: Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of \$750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of \$100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to \$25 million each year for up to five years.</p> <p>Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.</p>	<p>03/28/2019 Introduced; Referred to Committee on Health, Education, Labor, and Pensions</p>	<p>CalOptima: Watch</p>

2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 563 Quirk-Silva	Mental Health Funding for the North Orange County Public Safety Task Force: Would establish a two-year pilot program in Orange County with the appropriation of \$16 million from the General Fund to support those experiencing a mental health crisis. Funds to be allocated to the North Orange County Public Safety Task Force: \$8 million by January 1, 2020 and \$8 million by January 1, 2021. Funds would establish programs such as urgent and nonurgent telephone lines, case management, and a mobile response team.	05/16/2019 Committee on Appropriations; Held under submission 04/24/19 Passed Committee on Health 02/13/2019 Introduced	CalOptima: Watch Orange County Board of Supervisors: Support

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	California Generic Prescription Drugs: Would authorize the State of California to manufacture and manage their own generic prescription drugs.	01/13/2020 Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 741 Kalra	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Provider Training: Would expand provider training, for those providing EPSDT services, to include universal trauma screenings. Training would include how to administer and use the new trauma screening tool, providing care, proper diagnosis and referrals for patients who have tested positive in trauma screenings, and connecting patients to proper resources and care.	05/16/2019 Committee on Appropriations; Held Under Submission 04/24/2019 Passed Committee on Health 02/19/2019 Introduced	CalOptima: Watch

2019–20 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	Nurse Practitioners: Would permit nurse practitioners to open and operate their own private practice. Would also permit a board-certified nurse practitioner to perform specific functions, without supervision by a physician and surgeon, in settings such as clinics, medical group practices, and health care agencies.	<p>05/16/2019 Hearing postponed at the request of the Appropriations Committee</p> <p>05/15/2019 Committee on Appropriations; Suspense file</p> <p>04/11/2019 Passed Committee on Business and Professions</p> <p>02/20/2019 Introduced</p>	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	Federally Qualified Health Center (FQHC) Reimbursement: 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 an FQHC to be reimbursed for a 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. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	<p>09/13/2019 Carry-over bill; Moved to inactive filed at the request of the author</p> <p>08/30/2019 Passed Assembly Committee on Appropriations</p> <p>05/23/2019 Passed Senate floor</p> <p>01/08/2019 Introduced</p>	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 316 Ramos/Rivas	Medi-Cal Dental Services: 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 special needs uses more time and resources than originally allocated. Would allow the member four dental visits within a twelve-month period. The reimbursement rate would increase from \$100 per visit to \$140 per visit with support from Proposition 56 dollars.	<p>05/17/2019 Committee on Appropriations; Held Under Submission</p> <p>04/10/2019 Passed Committee on Health</p> <p>01/30/2019 Introduced</p>	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	<p>Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019: Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also:</p> <ul style="list-style-type: none"> ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes. 	10/30/2019 Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support
S. 2741 Schatz	<p>Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019: Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also:</p> <ul style="list-style-type: none"> ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes. 	10/30/2019 Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support

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

CAHP: California Association of Health Plans

CalPACE: California PACE Association

LHPC: Local Health Plans of California

NPA: National PACE Association

Last Updated: January 15, 2020

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
April 24	Last day for policy committees to hear and report bills to fiscal committees
May 1	Last day for policy committees to hear and report non-fiscal bills to the floor
May 15	Last day for fiscal committees to report fiscal bills to the floor
May 26–29	Floor session only
May 29	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 2–August 3	Summer recess
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: <http://assembly.ca.gov/legislativedeadlines>

About CalOptima

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

California State Budget: FY 2020-21 Proposal Analysis and CalOptima Impacts

January 2020

Overview

On January 10, 2020, Governor Gavin Newsom released his fiscal year (FY) 2020-21 state budget proposal. The total proposed budget is \$222.2 billion, with General Fund spending at \$153.1 billion, which is approximately two percent higher than current year spending.^[i] The budget anticipates that the state's economy and associated revenues will grow at a modest rate – 3.8 percent – slower than previous expectations, but still enough to drive an ambitious policy agenda.

Specific to health policy, Governor Newsom is continuing to focus on the priorities funded in last fiscal year's budget, including expanding access to health care via Medi-Cal, controlling prescription drug costs and addressing both the homelessness and housing affordability crises affecting the state. All of these priorities received a significant amount of attention in his press conference as well as the written budget proposal. Governor Newsom announced a plan to expand Medi-Cal to cover undocumented seniors, proposed that California start its own generic drug label and proposed an additional \$1 billion in funding to address the homelessness crisis, which he called the "issue that defines our times." These topics are covered in more detail below. The governor also proposes funding for new initiatives that were not priorities in the prior year's budget, but that complement his administration's focus on healthcare and quality of life issues. To this end, the budget endorses and funds Medi-Cal Healthier California for All (formerly "CalAIM") proposals to the tune of \$695 million.

The Medi-Cal Budget

The increase in General Fund dollars allocated to Medi-Cal funding (see table 1 below) is based on an estimated Medi-Cal enrollment of 12.9 million members in fiscal year (FY) 2020-21, which is a slight increase (less than one percent) as compared to FY 2019-20.²

FY 2020–19 Proposed Medi-Cal Budget³

General Fund	\$26.4 billion
Federal Funds	\$67.5 billion
Other	\$13.4 billion
Total	\$107.4 billion⁴

The federal portion of the Medi-Cal budget is funded through several avenues. For original Medi-Cal, also known as Medi-Cal classic, there is a 50/50 federal/state funding match. For the Medi-Cal expansion (MCE) population, there is an enhanced federal match (90/10 for 2020 and subsequent calendar years).⁵ For the Children's Health Insurance Program (CHIP) population, which was carved in to Medi-Cal in 2013, there is currently an 88/12 match.

Of note, the 2019-20 budget increased funding for Proposition 56 programs, creating several new ones, but attached a December 31, 2021 sunset date to the funding. The governor is proposing to push the sunset date of Proposition 56 programs by 18 months, to July 31, 2023, due to the anticipated surplus as well as the state's expectation that the latest iteration of the MCO tax* will be approved by CMS, albeit not in time to generate revenue for this fiscal year. In his budget announcement, Governor Newsom stated that he expected MCO tax funding – anticipated to be between \$1.2 and \$1.9 billion – to impact the 2021-22 Medi-Cal budget, at the earliest.

Medi-Cal Healthier California for All (The Program Formerly Known as CalAIM)

The governor is pursuing an ambitious agenda to transform the Medi-Cal delivery system to expand both access to care and the types of services available. Much of this agenda is captured in the Medi-Cal Healthier California for All initiative, which received a \$695 million allocation in the FY 2020–21 budget proposal. This funding will cover enhanced care management and in lieu of services, as well as infrastructure investments needed to expand whole person care programs statewide.⁶ Funding commitments are expected to increase in upcoming fiscal years as more Medi-Cal Healthier California for All programs are launched. Of note, the package of proposals that comprise Medi-Cal Healthier California for All will need federal approval before they can be initiated. DHCS plans on submitting the requisite applications to the Centers for Medicare & Medicaid Services (CMS) in summer 2020, contingent on feedback received from affected stakeholders as well as state funding allocated as part of the final FY 2020-21 budget.⁷

*On January 31, 2020, CMS rejected California's proposal to reinstate the MCO tax, basing the denial on the hold harmless structure of the tax.

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Expanding Full Scope Medi-Cal

The Medi-Cal budget also contains funding to expand full-scope Medi-Cal to cover undocumented seniors age 65 and older, no sooner than January 1, 2021. This expansion is projected to bring 27,000 new enrollees into the program statewide. The budget proposal includes \$80.5 million (\$64.2 million General Fund) for this expansion, including In-Home Supportive Services costs, in FY 2020-21. Beginning FY 2022-23, these costs are expected to be approximately \$350 million (\$320 million General Fund) per year.⁸

Efforts to Control Prescription Drug Prices

Another major piece of Governor Newsom's health policy agenda is the effort to reduce prescription drug costs. Last year, his emphasis was on bulk purchasing of prescription drugs, effectuated partly through the pharmacy carve-out. In January 2019, Governor Newsom issued Executive Order N-01-19 to carve prescription drugs out of Medi-Cal managed care and transition the benefit to state administration, no sooner than January 1, 2021.⁹ DHCS is continuing to work on the process of this transition and has selected a vendor, Magellan Medicaid Administration, to administer the benefit once it is transitioned over.¹⁰ Of note, the budget assumes that the majority of the financial benefit from the carve-out, amounting to "hundreds of millions of dollars in annual General Fund savings," will not accrue to the state until FY 2022-23.¹¹ The budget proposal estimates that the state will benefit from \$178.3 million in savings associated with the carve-out during FY 2020-21.¹²

To build on these efforts, the governor is also proposing that California negotiate partnerships with generic drug manufacturers to establish the state's own generic drug label, with the aim of building toward a single market for drug pricing within the state.¹³ During his press conference announcing the budget, the Governor Newsom shared that the state is currently negotiating with drug manufacturers and that further details regarding this proposal would be forthcoming in the spring.

Office of Health Care Affordability

Also of note, the governor is planning to create a new Office of Health Care Affordability under the California Health and Human Services Department. It is unclear how this office would impact Medi-Cal, but it is clear that the governor would like his health policy agenda to dovetail with his broader focus on affordability and quality of life issues facing California residents. The Office's prime directives would be to increase price and quality

transparency by developing industry-specific strategies and cost targets as well as "financial consequences for entities that fail to meet these targets."¹⁴

Other Health Priorities

Behavioral Health: The Governor proposes to establish a Behavioral Health Quality Improvement Program to fund county mental health plans and substance use disorder systems to prepare for Medi-Cal Healthier California for All. The funding of \$45.1 million GF in FY 2020-21 and \$42 million in FY 2021-22¹⁵ is intended to assist these delivery systems in developing improvements to data-sharing capabilities for care coordination, performance measurement, and payment reform.

Public Option: The Governor's priorities also include specific reference to public Medi-Cal managed care plans. The Budget includes a statement that the Administration plans to leverage California's public Medi-Cal managed care plans and Covered California to "build an even more robust public option in California."¹⁶

Homelessness: The 2019-20 budget invested \$1 billion in this effort, including \$650 million in emergency aid to local governments and hundreds of millions of dollars for expanded health and social services targeted to homeless individuals and individuals at risk of becoming homeless.¹⁷ The proposed 2020-21 budget includes \$750 million (one-time, General Fund) to establish the California Access to Housing and Services Fund, administered by the state's Department of Social Services. The Fund would be dedicated to moving individuals as well as families into stable housing and funds would "flow through performance-based contracts between the state and regional administrators and [would] be subject to a 10-percent administrative cap."¹⁸ Additionally, many of the Medi-Cal Healthier California for All programs are designed to address the needs of California's homeless population. Medi-Cal Healthier California for All proposals adapt and expand whole person care (WPC) principles into a statewide program and empower plans to address social determinants of health as appropriate, such as housing navigation and other social services.¹⁹

Next Steps

Many of these policy changes are predicated on the new administration's expectation that the state's economy will experience moderate growth in the next fiscal year. The governor's May Revise of the budget proposal could include adjustments based on a revised economic outlook or potential federal policy changes, such as CMS' proposed Medicaid Fiscal Accountability Regulation. We will continue to follow these proposals closely as

State Budget Proposal Analysis and CalOptima Impacts (continued)

they move through the budget process. Many of these proposals, such as the expansion of full-scope Medi-Cal, will require additional legislation to implement. Specific to the expansion, DHCS will propose trailer bill language to implement this change and it is likely to be dependent on systems changes and network readiness approvals being in place.

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

Endnotes

¹ Governor's Budget Summary 2020-21, Appendix 5, available at: <http://www.ebudget.ca.gov/2020-21/pdf/BudgetSummary/FullBudgetSummary.pdf>

² Ibid., p. 24

³ DHCS, "2020-21 Governor's Budget Highlights," p. 3, available at: https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2020-21-Governor%27s-Budget-Highlights.pdf

⁴ Governor's Budget Summary 2020-21, p. 32, available at: <http://www.ebudget.ca.gov/2020-21/pdf/BudgetSummary/FullBudgetSummary.pdf>

⁵ Chernew, Michael. "The Economics of Medicaid Expansion," Health Affairs Blog, available at: <https://www.healthaffairs.org/doi/10.1377/hblog20160321.054035/full/>

⁶ Governor's Budget Summary 2020-21, p. 33, available at: <http://www.ebudget.ca.gov/2020-21/pdf/BudgetSummary/FullBudgetSummary.pdf>

⁷ DHCS, "Medi-Cal Healthier California for All, Executive Summary," p. 14, available at: <https://www.dhcs.ca.gov/provgovpart/Documents/6422/Medi-CalHealthierCAforAllExecSummary.pdf>

⁸ Ibid., p. 34

⁹ DHCS, "2019-20 Governor's Budget Highlights," p. 6, available at: https://www.dhcs.ca.gov/Documents/Budget_Highlights/FY2019-20-GB-Highlights.pdf

¹⁰ Medi-Cal Rx Advisory Group, PowerPoint presentation, available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MRX_Advisory_Workgroup_01-14-20.pdf

¹¹ Governor's Budget Summary 2020-21, p. 27 available at: <http://www.ebudget.ca.gov/2020-21/pdf/BudgetSummary/FullBudgetSummary.pdf>

¹² Ibid., p. 35

¹³ Ibid., p. 28

¹⁴ Ibid., p. 26

¹⁵ Ibid., p. 33

¹⁶ Ibid., p. 26

¹⁷ Ibid., p. 104

¹⁸ Ibid., p. 106

¹⁹ Ibid., p. 107

About CalOptima

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

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

TC Roady

Director, Regulatory Affairs and Compliance
(714) 796-6122; troady@caloptima.org

Jackie Mark

Senior Policy Analyst, Regulatory Affairs and Compliance (Government Affairs)
(657) 900-1157; jackie.mark@caloptima.org

Julie Bomgren

Manager, Regulatory Affairs and Compliance (Government Affairs and Policies & Procedures)
(714) 246-8836; jrbomgren@caloptima.org

STRATEGIC PLAN 2020-2022



A Public Agency

CalOptima
Better. Together.

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A Message From the CEO

Like many of you, I consider the beginning of the new 2020 decade as an opportunity to look ahead and to plan. So, it is the perfect time to launch CalOptima's next Strategic Plan, for 2020-2022. The guidance it offers and the priorities it sets have been carefully considered by a wide variety of leaders, including our Board of Directors, advisory committee members, executive staff, community stakeholders and industry consultants. Collaboration strengthens our plan and reflects our Better. Together. approach to quality health care for Orange County's vulnerable low-income residents.

If this decade is anything like the last, the one constant will be change. Recognition of this fact is central to the content of CalOptima's Strategic Plan. An overview of the health care landscape explains the federal, state and local drivers of change, followed by our strategic priorities and objectives in this environment.

Responding effectively in dynamic conditions does not mean CalOptima will alter our mission or vision, both of which are focused on members. Our commitment to members is as strong as ever, and you will see that dedication underlying all the priority areas, from innovation and community partnerships to value, quality and operational excellence. While we may adjust our efforts along the way in response to regulatory changes or community needs, we will not waver about putting members first.

And one final comment about 2020 — it's CalOptima's 25th anniversary year. We celebrate you and all the providers, community-based organizations, elected officials and stakeholders who partner with us. Together, we have accomplished so much, including statewide recognition year after year as a leading Medi-Cal health plan. Our shared goal of a healthier Orange County has brought us far and will carry us confidently into the future.



Michael Schrader
Chief Executive Officer

About CalOptima

CalOptima's Mission

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

CalOptima's Vision

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

Programs

Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan): For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for worldwide emergency care, dental care, vision care and fitness. Other benefits are transportation to medical services and a Personal Care Coordinator.

OneCare (HMO SNP): A Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Benefits are covered in one single plan, making it easier to get health care.

Program of All-Inclusive Care for the Elderly (PACE): A long-term comprehensive health care program that helps older adults remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal.

As of October 31, 2019, CalOptima has approximately 743,000 members:

Medi-Cal: 727,437

OneCare Connect: 14,093

OneCare: 1,567

PACE: 368

Health Insurance Coverage in Orange County

CalOptima covers more than 20% of Orange County residents.

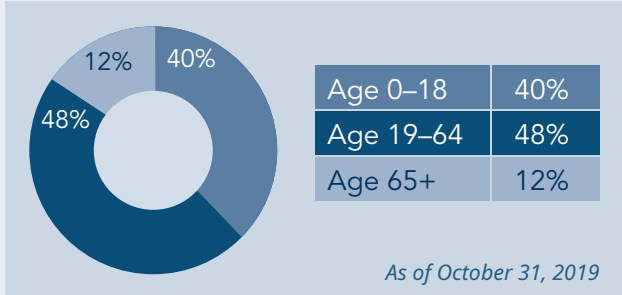
Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%
Medicare and Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-Based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

Source: California Health Interview Survey, 2017



CalOptima Profile

Members by Age



Low Administrative Costs

CalOptima spends nearly 96 cents of every dollar on member care and only 4 cents on program administration, which reinforces our commitment and mission as a community health plan that provides quality health care services in a cost-effective, compassionate manner.

96¢ of every **\$1**

Provider Network Composition

CalOptima has a strong provider network to serve our members. As of October 31, 2019, this includes:

- 1,567 primary care providers
- 6,944 specialists
- 40 acute and rehab hospitals
- 35 community health centers
- 570 pharmacies
- 100 long-term care facilities
- 5 PACE alternative care settings

High-Quality Care

CalOptima offers high-quality care to our members:

- For five years in a row, CalOptima was the top rated Medi-Cal plan in California, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings (2014–2019).
- For 2019–2020, no other health plan received a higher rating.
- NCQA has awarded an accreditation status of Commendable to CalOptima Medi-Cal.

Health Care Landscape Review

CalOptima's 2020–2022 Strategic Plan reflects the need to be responsive to a wide variety of federal, state and local priorities, considerations and issues. The landscape review is a summary of highlights from a comprehensive Environmental Scan that was completed to inform the Strategic Plan.

Federal Landscape

At the federal level, the policy landscape has been characterized by uncertainty for the past three years, and this is expected to continue for the foreseeable future. The Centers for Medicare & Medicaid Services (CMS), which provides the federal funding for, and oversight of, California's Medi-Cal program, has established a set of strategic priorities focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. CalOptima will look to CMS's goals to prioritize development of innovative approaches that are aligned with the federal government. In addition, federal immigration policy may negatively impact Medi-Cal enrollment.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Gavin Newsom. Governor Newsom has an ambitious health care agenda focused on expanding coverage for all Californians and reigning in costs. Within the California Department of Health Care Services (DHCS), key initiatives are underway that will shape the future of the Medi-Cal program and impact CalOptima's work over the next three years.

Medi-Cal Vision: 2021 and Beyond

The current federal Section 1115 Medicaid waiver, referred to as Medi-Cal 2020, expires at the end of 2020. As part of renewing the waiver, DHCS has launched a major restructuring of Medi-Cal, known as California Advancing and Innovating Medi-Cal (CalAIM), which is designed to reduce the complexity of the program, focus on population health and increase the use of value-based purchasing strategies. CalOptima will contribute to the CalAIM discussions and, ultimately, to the implementation of Medi-Cal's next chapter.

Prescription Drug Carve-Out

On his first day in office, Governor Newsom signaled his intent to address rising pharmacy costs by shifting to bulk purchasing of

prescription drugs for all government programs, including Medi-Cal (the largest purchaser in the state). CalOptima will continue to work closely with DHCS on the design of the carve-out to minimize the impacts on our members and their health.

Future of the Coordinated Care Initiative and Cal MediConnect

The Coordinated Care Initiative (CCI) focuses on integrating delivery of medical, behavioral and long-term services and supports (MLTSS) benefit into California's Medi-Cal care delivery system. The CCI also includes the Cal MediConnect (CMC) duals demonstration, combining Medicare and Medi-Cal into a single program. CCI and CMC are currently operating in only seven counties and the federal authority for CMC is scheduled to sunset on December 31, 2022. As part of the CalAIM initiative, DHCS has proposed that all Medi-Cal managed care plans, including CalOptima, be required to operate a Dual Eligible Special Needs Plan (D-SNP) by January 1, 2023, and assume responsibility for all Medi-Cal long-term care services effective January 1, 2021. CalOptima will engage with DHCS and CMS on the CCI and CMC transitions.

Health Care Landscape Review (continued)

Orange County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. As the sole Medi-Cal plan in the County, CalOptima is in a unique position to impact care delivery and partner with County agencies and other stakeholders to improve access to care and quality for all members.

Homelessness and Behavioral Health

In Orange County, as across the state, the population of individuals experiencing homelessness has increased significantly over the past few years. Orange County has focused on developing a system of care that recognizes a multifaceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed enhanced funding for homeless health programs in the County. For example,

CalOptima is funding programs in collaboration with its community health centers to provide members on-call medical services in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, and supporting hospital discharge coordination, recuperative care and respite care.

In 2018, local public and private stakeholders came together to work on behavioral health issues. Under this initiative, known as Be Well OC, a regional wellness center will be constructed in Orange County to serve individuals with mental health needs regardless of payor source. CalOptima is participating in this collaborative by prepaying for services at the Be Well OC wellness center. Be Well OC is part of the larger Mind OC initiative to integrate

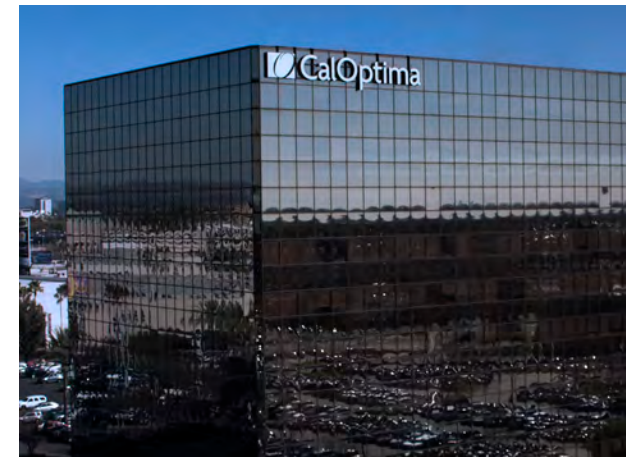
behavioral health services across silos to address social determinants of health.

CalOptima Workforce Needs

CalOptima will continue to face an extremely competitive employment environment over the next three years. The high cost of living in Orange County coupled with the County's low unemployment rate, staff retirements and turn-over contribute to a tight labor market.

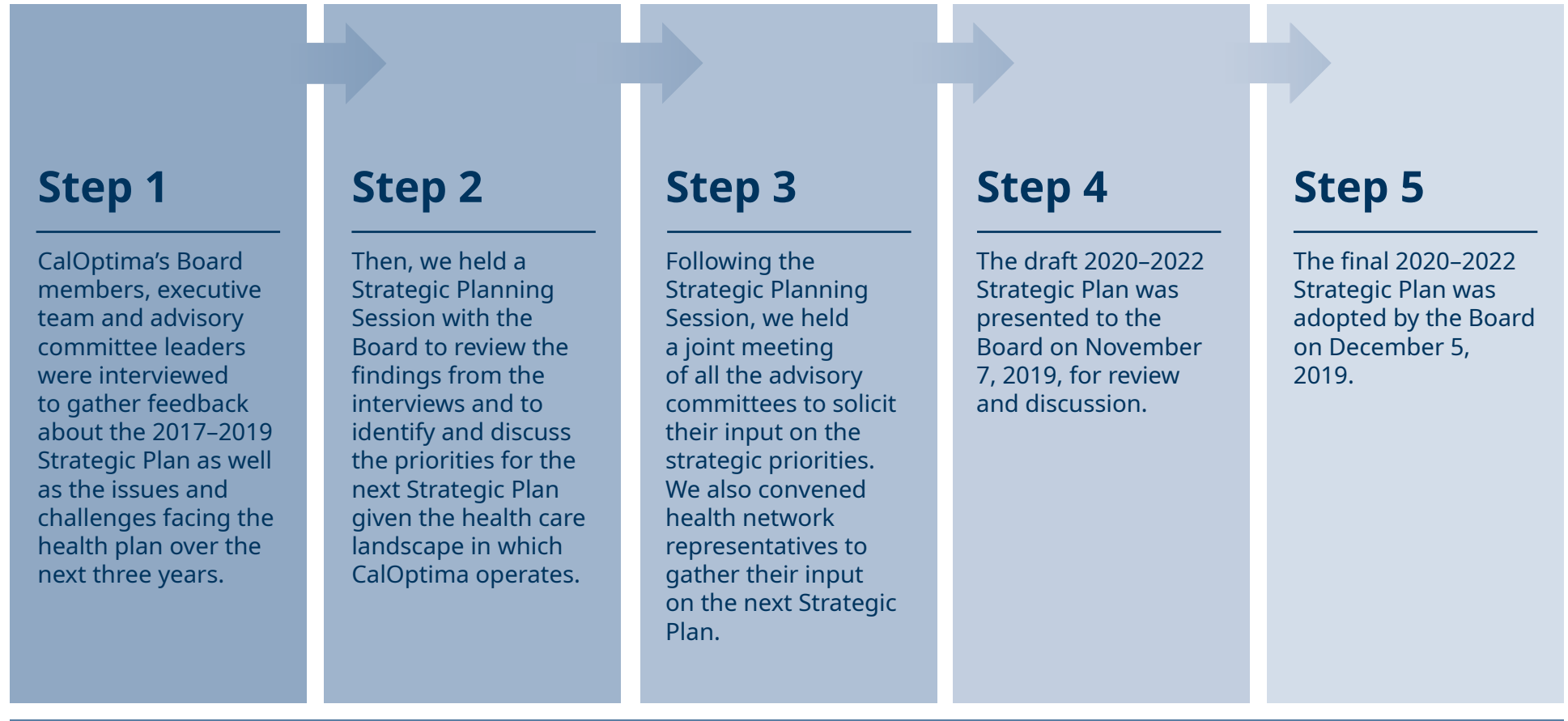
Physician Networks and Access to Care

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. To address access issues, CalOptima will continue to develop stronger networks with innovative value-based payment arrangements over the next three years.



Strategic Plan Development Process

To develop our 2020–2022 Strategic Plan, we gathered input from a wide range of CalOptima stakeholders:



Strategic Priorities and Objectives

Our members are the essential focus of the Strategic Priorities and Objectives for the 2020–2022 Strategic Plan and are supported by the programs and services provided by CalOptima.



Innovate and Be Proactive

- Anticipate Likely CMS and DHCS Priorities
- Identify and Collaborate on Local Priorities and Needs
- Leverage New Federal and State Programs and Services to Improve Access and Quality of Care for Members
- Seek Opportunities to Further Integrate Care for Members



Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service



Strengthen Community Partnerships

- Increase Collaboration with Providers and Community Stakeholders to Improve Care
- Utilize Strong Advisory Committee Participation to Inform Additional Community Engagement Strategies



Increase Value and Improve Care Delivery

- Evaluate and Implement Value-Based Purchasing Strategies that Drive Quality
- Deploy Innovative Delivery Models to Address Social Determinants of Health and Homelessness
- Maintain Focus on Providing High-Quality Care to Members



Enhance Operational Excellence and Efficiency

- Maintain Strong Culture of Compliance
- Preserve CalOptima's Financial Stability
- Invest in Infrastructure and Efficient Processes
- Engage Workforce and Identify Development Opportunities

Board of Directors

Paul Yost, M.D. (Chair)

Anesthesiologist, CHOC Children’s and St. Joseph Hospital
Designated seat: Licensed physician, representing a health network

Dr. Nikan Khatibi (Vice Chair)

Anesthesiologist, Pain Specialist and Addiction Medicine Physician
Designated seat: Licensed medical professional, not representing a health network

Ria Berger

CEO, Healthy Smiles for Kids of Orange County
Designated seat: Community clinic representative

Doug Chaffee

Orange County Board of Supervisors Supervisor, Fourth District
Designated seat: Orange County Board of Supervisors (alternate)

Ron DiLuigi

Retired Health Care Executive
Designated seat: Legal resident of Orange County

Andrew Do

Orange County Board of Supervisors Supervisor, First District
Designated seat: Orange County Board of Supervisors

Alexander Nguyen, M.D., MPH

Psychiatrist, Long Beach Veterans Affairs Medical Center
Designated seat: Family member of a CalOptima member

Lee Penrose

Health Care Executive
Designated seat: Current or former hospital administrator

Richard Sanchez, REHS, MPH

Director, Orange County Health Care Agency
Designated seat (non-voting): Orange County Health Care Agency

J. Scott Schoeffel

Attorney
Designated seat: Legal or finance professional

Michelle Steel

Orange County Board of Supervisors Supervisor, Second District
Designated seat: Orange County Board of Supervisors



A Public Agency

CalOptima

Better. Together.

505 City Parkway West, Orange, CA 92868
www.caloptima.org

The 2020–2022 Strategic Plan was created with the assistance of Athena Chapman and Caroline Davis from Champan Consulting. This plan was adopted by the CalOptima Board of Directors on December 5, 2019, and provides a framework for future direction. This document does not authorize expenditure of funds or commitment of resources.



CALOPTIMA
BOARD OF DIRECTORS
NETWORK STRATEGY
FINAL REPORT
FEBRUARY 6, 2020

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Prepared by Pacific Health Consulting Group and
Milliman, Inc.

Meeting Agenda

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Topic	Page
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Project Background and Approach	4
Network Organization, Population, and Reimbursement	8
Network Protocols and Management	33
Network Vision and Strategy	38
Recommendations and Road Map	44

Consulting Team

Pacific Health Consulting Group and Milliman

3



Bobbie Wunsch
Founder and Partner



Tim Reilly
Founder and Partner



Maureen Tressel Lewis
Healthcare Management Consultant



Barbara Culley
Healthcare Management Consultant

Project Background and Approach

Scope of Work

Network strategy analysis

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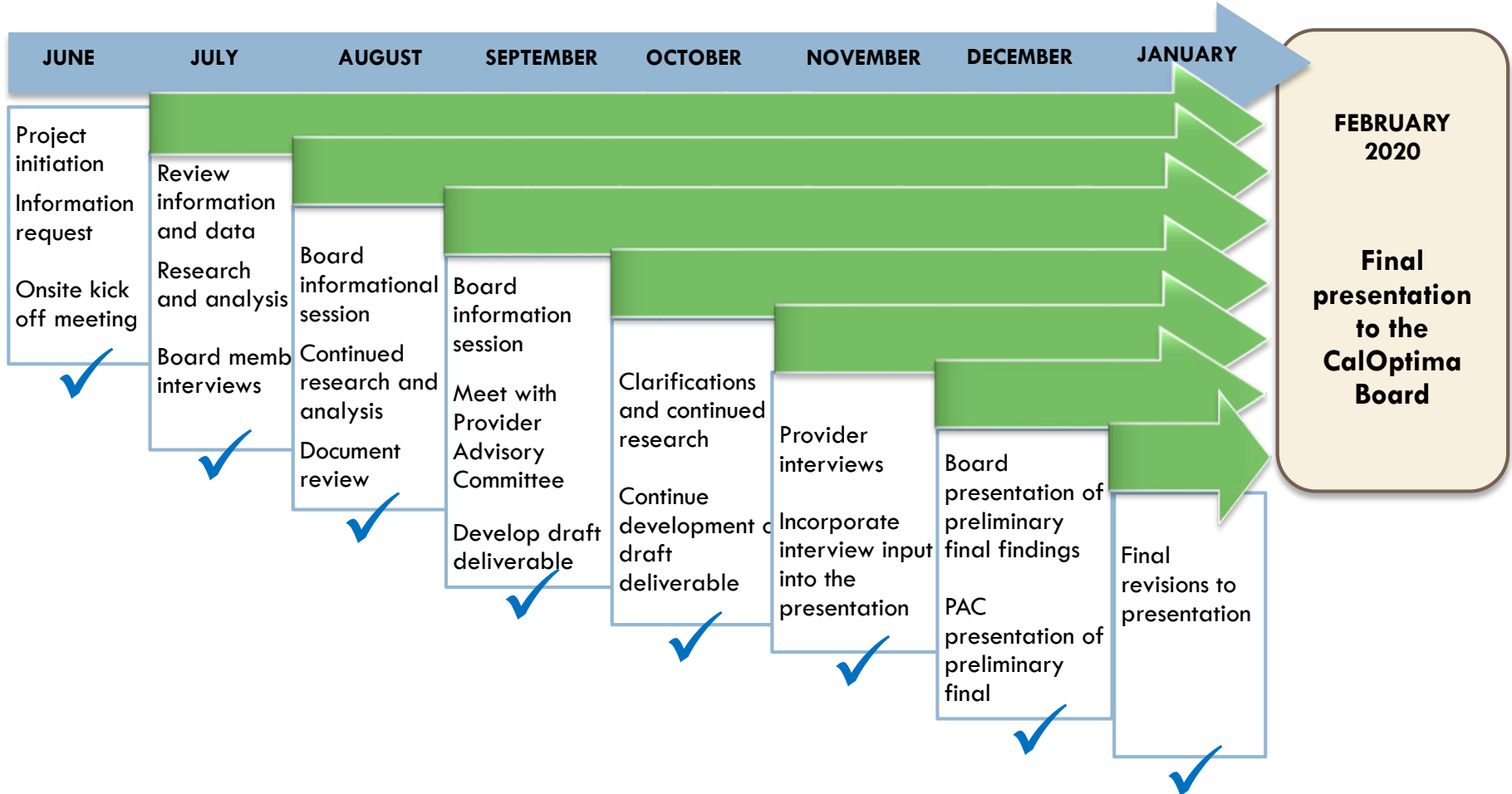
- CalOptima's RFP was structured around a set of 12 individual tasks/questions.
 - 4 new tasks added during engagement as opportunity to secure additional provider and Board input.
 - There is some overlap and dependencies across the 12 tasks.
 - This presentation is structured to align similar topics and concepts across the individual tasks.

RFP Task	Key Task
<i>Added task</i>	Board Interviews
<i>Added task</i>	Board presentation: network payment models
<i>Added task</i>	Board presentation: models to motivate network outcomes
<i>Added task</i>	Provider Advisory Committee/provider interviews
RFP Task 1	Review actuarial methodology
RFP Task 2	Review Medical Loss Ratio (MLR) analysis
RFP Task 3	Evaluate pre-contracting criteria
RFP Task 4	Analyze membership limitation approach
RFP Task 5	Evaluate auto assignment
RFP Task 6	Research provider payment methodologies
RFP Task 7	Develop network performance evaluation tool
RFP Task 8	Research network models
RFP Task 9	Analyze member satisfaction implications
RFP Task 10	Analyze provider satisfaction implications
RFP Task 11	Review administrative cost allocation model
RFP Task 12	Analyze Health Needs Assessment
RFP requirement	Final presentation

Project Approach

Structured project methodology and progress

6



Pacific Health Consulting Group

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Initial Network Findings

High-level observations informed by multiple sources

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- Multiple sources of information
 - Interviews
 - CalOptima staff interviews: 6/7
 - Board of Directors: 7/9, 8/1, 9/5, and 12/5
 - Provider Advisory Committee: 9/12 and 11/14
 - Provider interviews: 11/15 and 11/22
 - Materials and information
 - CalOptima documents, reports, and materials
 - Board minutes
 - Market practice information (numerous sources) - California market and national research
 - Comparison of CalOptima policies and practices with market are presented in Appendix

Observations

- Interviewees consistently stated a goal to use “best practices”.
- CalOptima uses established network practices in most areas.
- Several key improvement opportunities exist and are discussed in this report.

Provider Networks: Contracting and Organization, Population Characteristics, and Reimbursement

Categorizing Network Models

Consistent models nationally and California

9

Nationally, and in California, most types of networks can be categorized in the following groups:

- **Direct Contracted:** Contracts with individual providers. Delivery system organized and directly contracted by health plan. Individual Physicians or Physician Groups are typically paid Fee For Service (FFS) and the health plan organizes a system around them.
- **Partially Delegated:** Contracts with entities that organize part of the delivery system and are delegated a wide scope of professional benefits and administrative functions. Capitation is usually the main reimbursement method for the entity. Typical entities are IPAs and Medical groups.
- **Fully Delegated:** Contracts with entities that organize a complete delivery system and are delegated a full scope of benefits and administrative functions. These entities are paid capitation. ACOs, PHCs, Dual Capitated Hospitals and Physician Groups, and other HMOs are typical participants. In California these entities must be licensed by DMHC.

Key features of basic network types

Direct Contracted Networks

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- ❑ Health plan puts together a complete network of providers under contract.
- ❑ The health plan directly controls payments, quality programs, incentives, and utilization management (UM).
- ❑ Maximum control for plan and allows the network to be targeted to certain populations.
- ❑ Allows physicians to participate who may not be affiliated with organized physician entities.
- ❑ CalOptima's CCN Complex and CCN General are examples of these types of networks.

Key features of basic network types

Delegated Contracted Networks

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- There are two types of Delegated Networks: Full and Partial.
- Delegated entity puts together a complete network of providers under contract.
- The delegated entity directly controls payments, quality programs, incentives, and UM.
- Maximum control for provider organized networks and allows decisions about care to be made by the provider closest to the patient.
- The goal is a more provider integrated system.
- CalOptima's delegates Kaiser, HMOs, PHCs, and SRGs are examples of these types of networks. Kaiser is fully delegated. The other networks are partially delegated and the services delegated vary across networks.

CalOptima Networks

Membership and payment summary

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Model	Entities	Members	Percentage
Kaiser	1	44,557	6.0%
HMO*	3	118,215	16.0%
PHC**	3	210,235	28.7%
SRG	5	187,524	25.5%
CCN	-	77,333	10.0%
COD	-	98,873	13.8%
Total	12	736,737	100.0%

Model	Professional	Hospital	Pharmacy	Other Medical
Kaiser	Capitation	Capitation	Capitation	Capitation
HMO*	Capitation	Capitation	Fee-For-Service	Fee-For-Service
PHC**	Capitation	Capitation	Fee-For-Service	Fee-For-Service
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service
COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service

* HMO – Comprised of one entity; assumes both professional and hospital risk. Not to be confused with industry terminology.

** PHC – Comprised of two entities; one for professional risk and one for hospital risk

Source: CalOptima Delivery System Review, September 6, 2018, Greg Hamblin

CA MCMC Model Overview

Network models used in other MediCal plans

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- **LA Care:** LA Care is primarily a Delegated Network. Sub contracting HMOs (Kaiser, Anthem, and Blue Shield) and capitated IPAs with Shared Risk make up 95% of the network. LA Care is expanding its Direct Network at this time.
- **Inland Empire Health Plan (IEHP):** IEHP uses all three types of networks but its enrollment is mainly split between Delegated IPAs and a Direct Network. Kaiser has a small market share as well. IEHP has been expanding its Direct Network, particularly after two of its IPAs had compliance problems.
- **Other County Organized Health Systems (COHS):** Most of the other COHSs' networks are heavily dominated by Direct Networks and only utilize other types of networks when important providers insist on a particular model.

IEHP and LA Care Networks

Enrollment distribution across networks

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Enrollment by Network Type	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	112,392	0	8,548	0	554,531	508,074	1,183,545
LA Care	205,451	779,339	50,000	350,000	669,203	126,398	2,180,391

Enrollment Distribution	Kaiser	HMO	Restricted License	Dual Cap/PHC	Cap IPA/SRG	Direct	Total
IEHP	9.50%	0.00%	0.72%	0.00%	46.85%	42.93%	100.00%
LA Care	9.42%	35.74%	2.29%	16.05%	30.69%	5.80%	100.00%

CalOptima Networks Comparison

Comparing enrollment distribution across three key plans

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- Categorizing the networks to be comparable across plans

Enrollment by Network Type	HMO	Full Risk	Cap/Shared Risk	Direct	Total
IEHP	112,392	8,548	554,531	508,074	1,183,545
CalOptima	44,587	328,450	187,524	176,206	736,767
LA Care	984,790	400,000	669,203	126,398	2,180,391

Enrollment Distribution	HMO	Full Risk	Cap/Shared Risk	Direct	Total
IEHP	9.50%	0.72%	46.85%	42.93%	100.00%
CalOptima	6.05%	44.58%	25.45%	23.92%	100.00%
LA Care	45.17%	18.35%	30.69%	5.80%	100.00%

CalOptima Networks Comparison

Regional trends

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- The southern California region uses more capitation and delegation than northern California.
- Comparisons across CalOptima, LA Care, and IEHP networks.
 - ▣ LA Care and CalOptima started out with heavily delegated networks.
 - ▣ CalOptima utilizes in a significant fashion three different network types. LA Care and IEHP's use of network types is more concentrated.
 - ▣ All three plans have increased their Direct Networks over time.
- National trends are moving to value-based-purchasing contracts.
 - ▣ The value-based payment system rewards providers for efficiency, financial performance, and quality of care.
 - ▣ It also incentivizes providers to manage total cost of care.

CalOptima Network Characteristics

Comparison across CalOptima networks

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- The CalOptima Networks are difficult to compare since there is significant variation among them.
- CCN General Network members are older than average, and not surprisingly they have the highest risk score.
- The PHC Network members are younger by almost half from the average age and have the lowest risk score.
- The PHC Network is younger because the CHOC Health Alliance is primarily a children's network.

Network Characteristics

Member population characteristics

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- The Networks can be described by their member populations. Among the characteristics to be considered:
 - Aid/Rate Categories
 - Average Age
 - Risk Scores

CalOptima Network	Aid/Rate Category					Ave Age	Risk Score
	SPD	MCE	Child	Adult	Total		
CCN General	8%	45%	23%	24%	100%	33.4	1.06
HMOs	6%	42%	32%	19%	100%	30.3	1.03
PHCs	4%	18%	69%	9%	100%	16.8	0.97
SRGs	6%	45%	32%	17%	100%	30.3	0.95
Grand Total	6%	35%	43%	16%	100%	26.4	1.00

Provider Payment Methodologies

Payment methodologies used by Health Networks

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- CalOptima uses both fee-for-service and capitation to meet member and provider needs along a continuum of models.
 - A variety of models provides flexibility.
 - Each model has advantages and disadvantages.
 - CalOptima retains risk for high-cost services, e.g. pharmacy.

Model	Professional	Hospital	Pharmacy	Other Medical
Kaiser	Capitation	Capitation	Capitation	Capitation
HMO*	Capitation	Capitation	Fee-For-Service	Fee-For-Service
PHC**	Capitation	Capitation	Fee-For-Service	Fee-For-Service
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service
CCN	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service
COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service

* HMO – Comprised of one entity; assumes both professional and hospital risk

** PHC – Comprised of two entities; one for professional risk and one for hospital risk

Provider Payment Methodologies

Attributes of the current CalOptima practices

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□ **Capitation**

- Health Network is paid a per member per month (PMPM) rate.
 - Rates are approximately based on CalOptima Fee-for-Service (FFS) payment policies, methodologies, and actual, historical incurred utilization and costs.
 - HMO/PHC has capitation for some professional and hospital services, with some high risk carve outs (children's hospital, services approved without financial risk) and re-insurance paid on a FFS basis.
 - SRG has capitation paid for some professional services, with some carve outs and re-insurance paid on FFS basis.

□ **Fee-for-Service**

- Providers are paid an established fee for each service.
 - FFS rates are based on CalOptima's payment policies, methodologies, and fee schedules.
 - CCN payments are all FFS.
- Provider feedback on changing contracted methodology is that they are constrained in changing network types (e.g. from shared to full risk, which must be approved by the Board).
- CalOptima is utilizing all payment models. Each model has strengths and disadvantages.

CalOptima Capitation % by Network

Health care expense by type varies significantly across CalOptima networks

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- CalOptima's Networks are capitated at different levels.
- The more the Networks are delegated benefit responsibility, the more they are capitated
- Percent of CalOptima's Network expense (CY 2017) that is capitated:
 - CCN Complex 0%
 - CCN General 1.1%
 - HMO 65.9%
 - PHC 62.4%
 - SRG 32.4%
 - Total 40.3%

Reimbursement Options and Use

A wide variety of payment models are used nationally and in California

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- ❑ **Fee-for-Service (FFS):** Payment set by procedure code fee schedule. Incentivizes volume of services.
- ❑ **Bundled Payment:** Payment based on the estimated cost of all services for a problem, e.g. knee replacement. Incentivizes efficiency and quality of care to avoid the costs of complications or readmission.
- ❑ **Pay for Performance (P4P):** Payment base on provider's performance on agreed quality measures, e.g. readmission rates.
- ❑ **Shared Savings:** Only up-side risk, rewarded but not required to cover deficits.
- ❑ **Shared Risk:**
 - ❑ **Up-side Risk:** Aligned incentives to realize and share savings achieved through quality care impacting cost and utilization.
 - ❑ **Down-side Risk:** Aligned risk to share excess costs due to over-budget utilization and costs. Incentivizes quality of care, coordination of services, and holistic care.
- ❑ **Capitation:** Providers are paid a set amount for each member for a period of time, e.g. per member per month. The set amount is paid regardless of whether the member seeks care or not.

Incentive Types, Funding, and Impact

California limits downside exposure for providers

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Incentive	Funding Options	Anticipated Impact
Bonuses	Withhold/premium allocation	Bonus linked to outcomes can impact provider focus
Shared savings	Based on reduced costs and utilization (most California risk pools fall into this category)	Focus on quality and coordination of care to reduce readmissions and complications
Shared risk	Providers share downside when costs exceed the rate (limited in California)	Providers focus on outcomes to realize optimal care and efficiency which impact costs
Pay for Performance	Funded through savings realized by achieving performance goals, e.g. reduced readmissions	Aligned goals for quality of care and reduced costs

Incentive design elements

- Direct to providers, which allows tailoring of incentives
- Through delegated networks using contract expectations
- Providers understand incentive calculations and how to achieve incentives
- Targets and performance feedback are essential
- Timing for receiving incentives varies, e.g. quarterly versus annual

AmeriHealth Caritas

Managed Medicaid Managed Care Organization in 19 states

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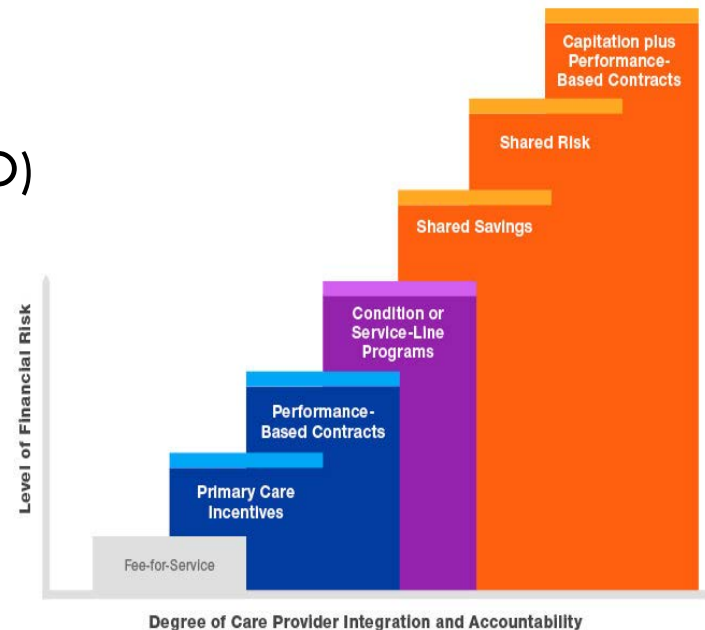
- Pay-for-performance bonuses to PCPs, specialists, hospitals, integrated delivery systems, and FQHCs.
- Shared savings bonus to integrated delivery systems in some areas.
 - ▣ Include trend and peer based measures on quality and efficiency measures, e.g. preventable admissions.
- Reward for timely, appropriate care and positive outcomes.
- Goal to reduce unnecessary inpatient and emergency utilization, improve outcomes, and decrease cost.
- Models include semi-annual capitation adjustments.
 - ▣ Upside only
 - ▣ Based on quality and cost guardrails
- Annual settlement parameters with interim payment stream.
- Performance metrics progress is available to providers via web-based dashboard.

United Healthcare

49.7 million lives Medicaid, Medicare, employer and individual plans

25

- Models range from Fee-for-Service to capitation.
- Provide support and resources to move providers toward value-based care models.
- Four network models:
 - ▣ Health Maintenance Organization (HMO)
 - ▣ Exclusive Provider Organization (EPO)
 - ▣ Preferred Provider Organization (PPO)
 - ▣ Point of Service (POS)



Source: <https://www.uhc.com/valuebasedcare/how-value-based-care-benefits-you/for-care-providers>

California Landscape

Regulatory considerations can influence payment models

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- Directed payment, e.g. Proposition 56, mandates that the plan is required to pay providers a supplementary amount that sometimes exceeds Medicare.
 - Goal is for increased quality and other performance targets.
 - Plan statutorily required to complete, not delegates.
- Various approaches to incentive payment method.
 - Direct to providers, which allows tailoring for providers.
 - Through delegated networks using contracted expectations.
 - Independent of delegated networks.

Network Models

Specialized networks for unique populations and required services

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- Considerations should be given to the types of networks needed as CalAIM (Medi-Cal Healthier California for All) transforms Medi-Cal Managed Care.
 - **High Cost and Dually Eligible:** CalOptima and other Plans have considered special networks for Renal Dialysis patients and other high cost patients as well as Dually eligible members where the plan does not hold the Medicare coverage.
 - **Institutionalized:** With the increased emphasis on LTC, networks specializing in the institutional populations should be considered (e.g. SNFists).
 - **Whole Person Care:** The transformation of Whole Person Care and the restructuring of Health Homes in MCMC may provide opportunities for new types of networks.
 - **Integrated Care Models:** DHCS is also encouraging the development of a more integrated model that includes Mental Health, Behavioral Health, and Dental Care.

Network Models

Reimbursement issues and considerations

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- New reimbursement policies for these developing areas should also be considered and incorporated into the overall network strategy.
- For example:

Should Acute Care hospital, Long Term Care (LTC) , and LTC support Services/ILOS and Enhanced Care Management services all be delegated and capitated to the networks?

If not, how does the plan keep the services financially aligned?

Actuarial Methodology Analysis

Actuarial methodology and MLR comparative analysis

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- Reviewed actuarial report on risk adjustment and expenses.
- Reviewed staff analysis of Medical Loss Ratios by actuarial determined risk scores.
- Compared the Network costs and FFS costs across the networks.
Note: Risk Adjusted and Unadjusted comparisons considered.
- Reviewed appropriate capitation rate comparisons.

Actuarial Methodology

Typical market practices

30

- Network encounter data was repriced based on the direct network FFS rates schedules.
 - ▣ This analysis is updated periodically to consider Capitation Rate levels.
 - ▣ The capitation rates paid were higher than the repriced encounters. This is not an unusual outcome as encounter data is typically missing a significant volume, and as such, did not trigger a lowering of the capitation rates.
- Making sure the Networks are fairly and comparably reimbursed should be a goal unless there is a mission based goal to expand a certain type of contract by offering favorable rates.

Risk Adjustment and MLR

Comparison across CalOptima Networks

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- There are significant differences in Risk Scores across the Networks which make MLR comparisons meaningless.
- MLR calculates the % of the revenue that is spent on payments to networks/providers. MLR does not include the necessary administrative costs inherent to plan operations.
 - 85% is usually seen as the minimally acceptable MLR, while public Plans usually are at a level close to 94%.

CalOptima Performance	CCN Complex	CCN General	HMO	PHC	SRG	TOTAL
Member Months	12,322	847,304	1,208,665	2,677,667	2,741,641	7,487,599
Imputed Risk Based Adjustment Factor	10.05	1.06	1.03	0.97	0.95	1.00

Risk Adjustment and MLR

Variation across networks and financial implications

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- CalOptima is maximizing the payments to networks/provider through its contracts when compared to its revenue.
- It is important to understand that Risk Adjustment methodologies have limited predictability and should be considered a partial answer to the question of how much risk there is in a population.
- CalOptima MLR and risk adjustment results varied.
 - There was significant variation of costs and risk across the networks.
 - The Direct Networks had greater costs per member month and higher risk scores than the Delegated Networks.
 - These results are based on review of CalOptima's MLR. CalOptima should also review the delegates' MLRs to better understand Network performance.

Provider Networks: Protocols and Management

Network Protocols

Policies and procedures to support network management

34

- Plan network management teams typically use a set of preapproved guidelines and processes to enable efficient and effective operations that support the overarching network strategy.
 - Processes are designed to be compliant with regulatory, accreditation, and other third party requirements.
 - Administrative procedures are clear and avoid unneeded complexity (and cost).
 - Day to day network management activities conducted by staff do not need Board participation or approval.
- These processes support a broad variety of network management activities such as:
 - Network participation requirements.
 - Contracting and delegation criteria
 - Network composition (e.g., number and type of providers, provider affiliations, panel size, PCP assignment)
 - Standard contracting terms and payment models.

Network Protocols

CalOptima practices and other plan trends

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- CalOptima has procedural requirements that may not add value to network management, composition, or quality.
 - Using RFP for network participation → administrative cost and complexity.
 - Complex pre-delegation audit → barriers for network expansion.
 - Auto assignment primarily on safety net and quality metrics → no tie to financial, access, or outcomes.

- Other plans nationally and in California have focused and streamlined practices to minimize or avoid these types of barriers.
 - Focus on complying with regulatory requirements without extra complexity.
 - Use financial, access, and outcomes measures to designed membership and related targets.
 - Board approved processes and criteria are used to conduct day to day network development and management, enabling Board to focus on mission, vision, and strategy goals.

Network Management

Using network data, analytics, and reporting in network performance management

36

- Plans typically develop key performance reporting that is distributed electronically to providers with specific target goals.
 - Individual performance awareness in comparison to peer group.
 - Reporting metrics are holistic, e.g. financial, quality, utilization, and satisfaction.
 - Also supports requirement for plan oversight.
- Reporting is designed to align with provider needs.
 - Format and content are intuitive and aligned with performance goals.
 - Focused on the critical few measures with access to detail if needed.
 - Performance drives consequences, e.g. incentives or contracting duration.
- National direction toward greater transparency, e.g. public disclosure of some metrics.

Network Management

Current practices

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- CalOptima creates quality metric related reporting – it has limited distribution.
- IEHP and LA Care send multi-faceted performance reports to providers.
 - Includes quantitative and qualitative results, e.g. the number of members, member utilization data (e.g., ER visits, admissions, etc.), financial results, encounter data per member per year by IPA, HEDIS measures achievement rate, goal rate.
 - LA Care is considering public disclosure of results.

Example report



Network Vision and Strategy

Network Vision and Strategy

Typical market practices

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- Plans develop a network strategy as a framework for developing and maintaining the network of providers needed to support the plan's current and forecast membership.
- Network strategy should be tightly aligned with a plan's:
 - Mission statement
 - Strategic plan
 - Financial, quality, and access goals
 - Operating environment/market characteristics
- Network strategy details may shift over time, but should be integral to the overall network management model.

Example Network Vision

Network vision should be aligned with the mission statement

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CalOptima mission statement:

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



STRATEGIC PRIORITIES

Innovation

Value

Partnerships and
Engagement

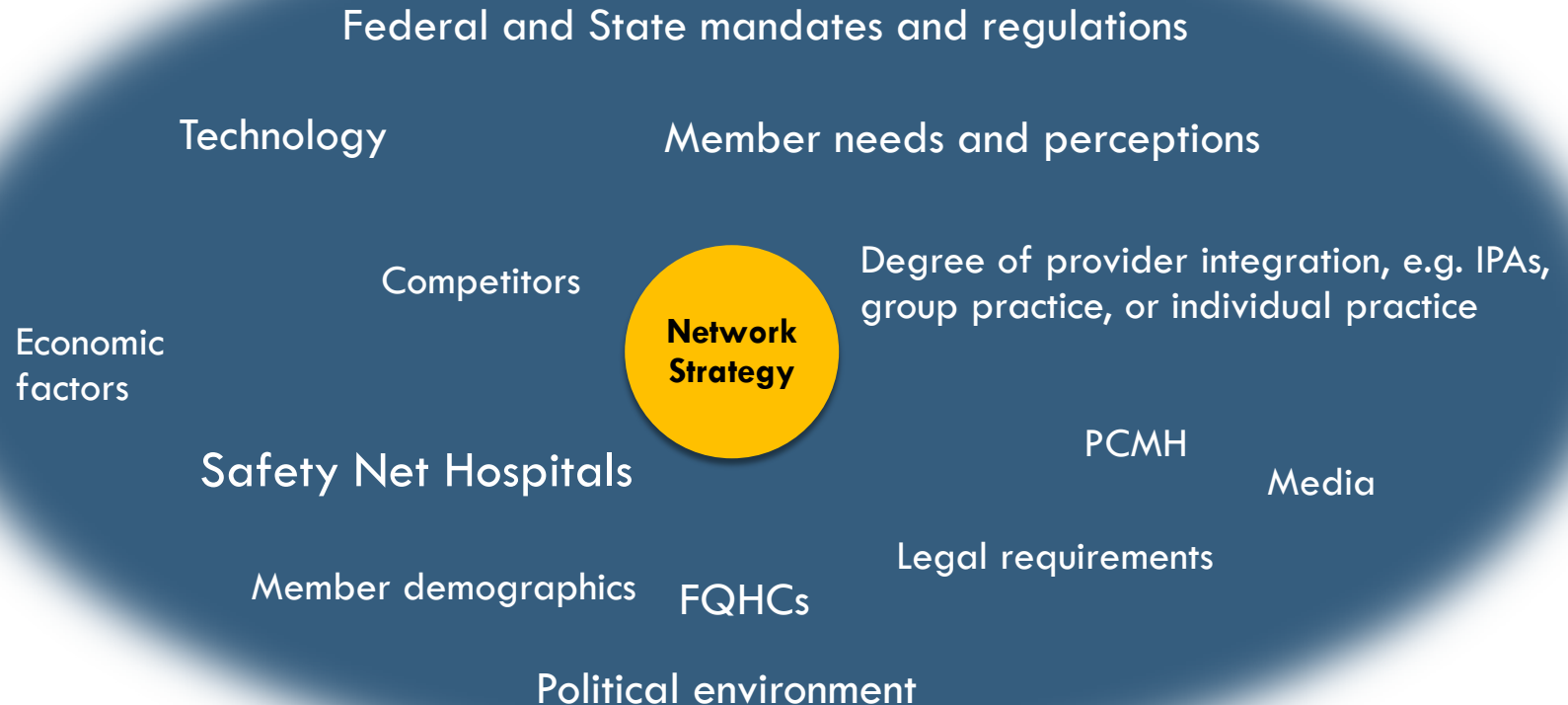
Network strategy vision (example):

Maximize the providers caring for Medi-Cal members to improve the overall quality and cost efficiency of the delivery system

Network Strategy

Network strategy is influenced by multiple factors unique to the plan environment

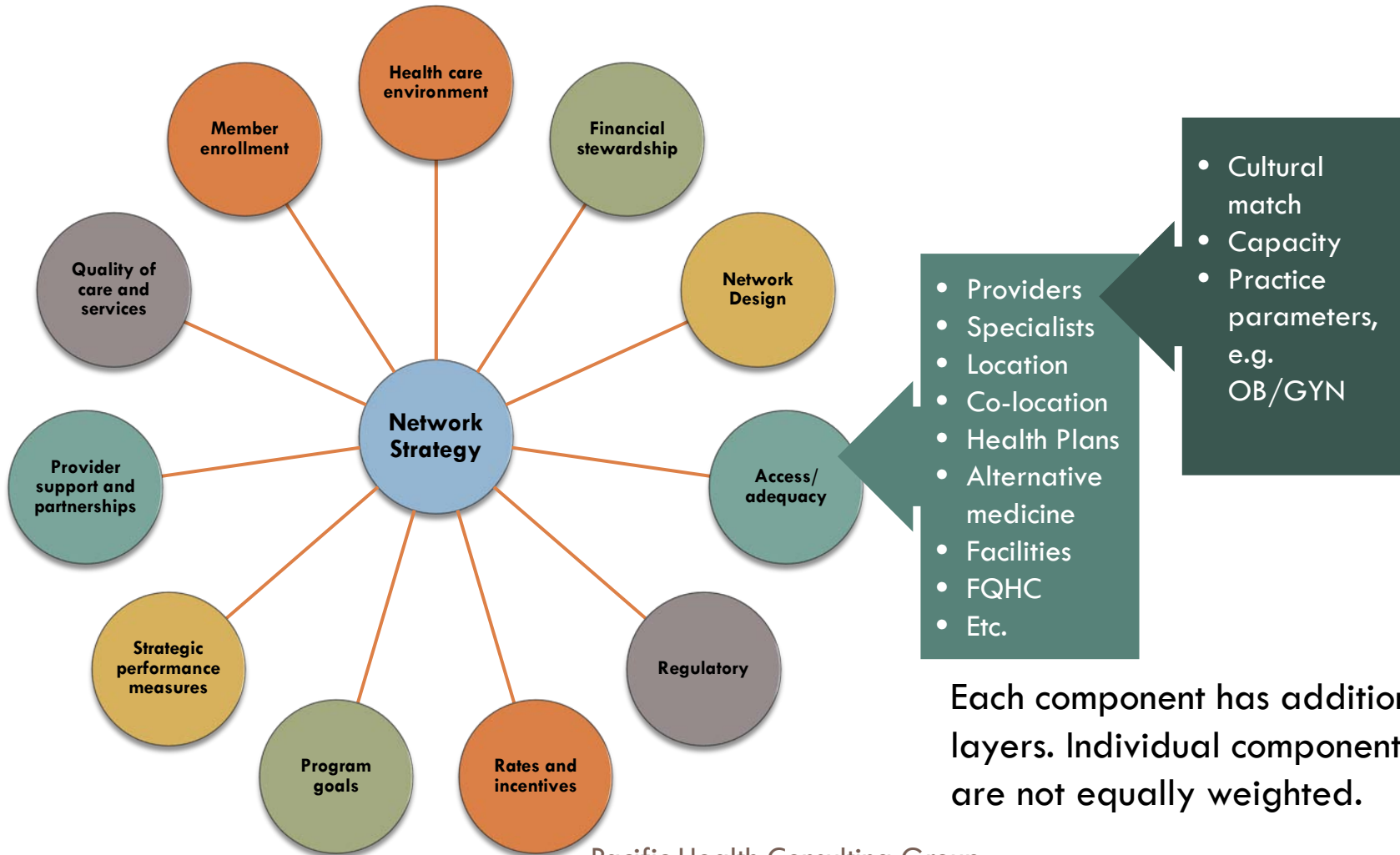
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Network Strategy Components

Major elements comprising network strategy with detailed sub-topics for focus and planning

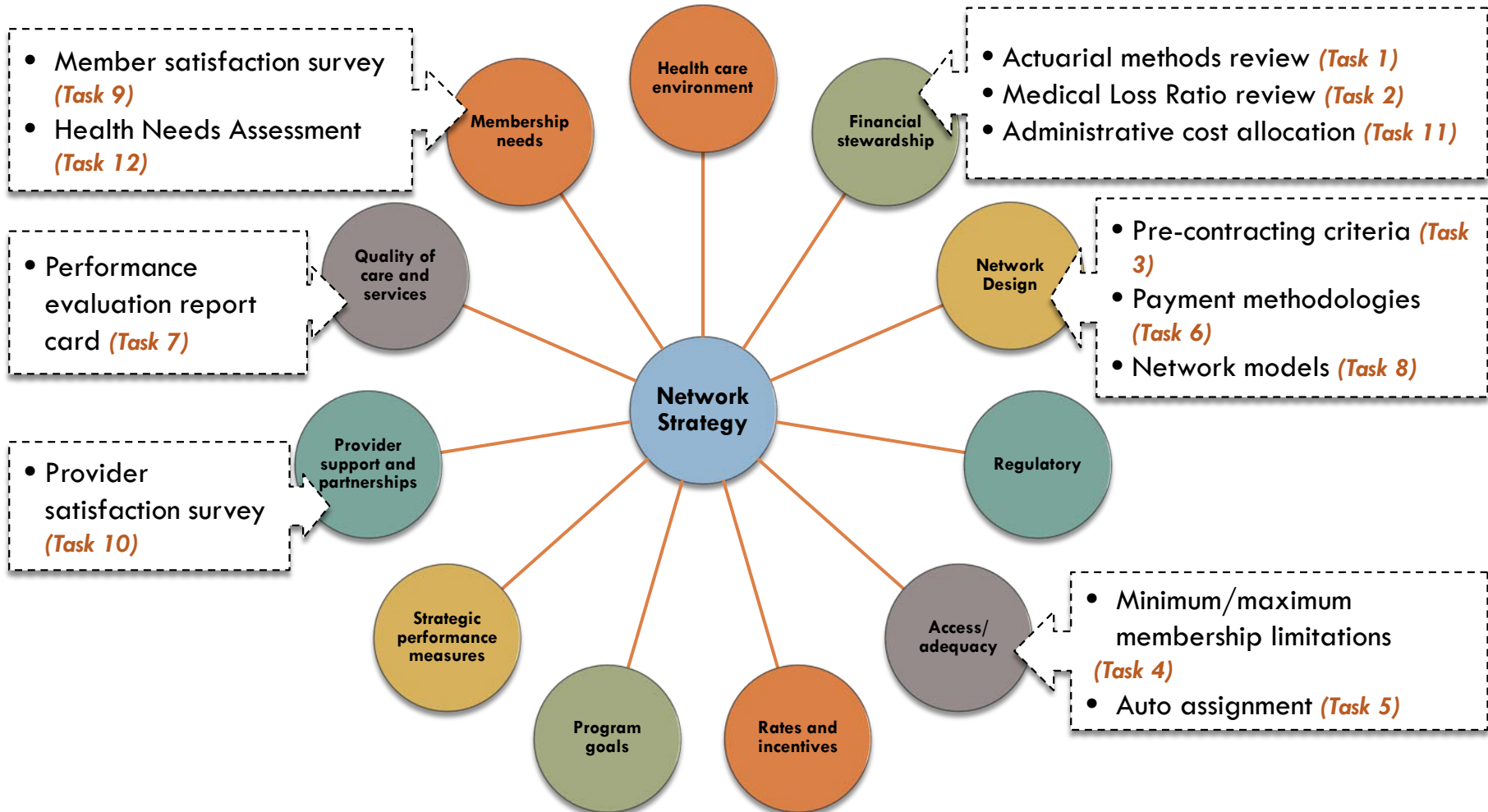
42



Each component has additional layers. Individual components are not equally weighted.

Engagement Scope of Work

The scope of work focused on selected components of a comprehensive network strategy



Recommendations and Road Map

Five Overarching Recommendations

Opportunities for improvement

45

Begin with a **CLEAR NETWORK VISION** of CalOptima Board objectives for network access, adequacy, and cost and quality performance

Create a comprehensive **NETWORK STRATEGY DOCUMENT** that supports the CalOptima mission and vision with prioritized activities to meet network cost and performance goals

Add networks/IPAs to the network if needed to **FILL HEALTH PLAN NEEDS**, e.g. access, services, and specialties, and add any physician meeting criteria to the direct network

REMOVE BARRIERS to contracting that add administrative costs, e.g. RFP process previously used

INCREASE TRANSPARENCY AND ACCOUNTABILITY in network performance by reporting outcomes in relation to other networks with assistance to reach performance goals, particularly for essential service providers

Network Vision and Strategy

Foundational elements for CalOptima network construct

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Recommendations

- Begin with a clear network vision based on CalOptima Board objectives for network access, adequacy, and cost and quality performance.
- Document the network strategy and describe the rationale behind the strategy in a Board approved publically transparent document.
- Create a comprehensive network strategy that supports the CalOptima mission and vision.
 - Incorporate prioritized actions to meet network cost and performance goals.
 - Include quantitative goals (e.g., MLR goals, risk retained by plan and amount delegated to networks, etc.) as well as qualitative goals (e.g., quality and satisfaction).

Network Composition

Ensure networks meet current and anticipated future needs

47

Recommendations

- Add networks/providers to the network if needed to fill health plan needs, e.g. access, services, and specialties, and add any physician meeting criteria to the direct network.
 - Add physicians/groups when they significantly add to physician capacity.
 - Determine whether to modify network contracts (e.g. full or partial capitation, carved out services) to increase transparency and accountability, e.g. for total cost of care.
 - Consider how and whether to add specialty networks to meet special population requirements.
- Structure network payment models to support long term financial goals.
 - Capitation payments to Networks models should be targeted to keep total network % of premium at a level to allow CalOptima to retain sufficient administrative dollars and margin contribution. Overall MLR targets of 94% and ALR of under 5% are common for Public Plans.
 - Establish a connection between CalOptima reimbursement practices and DHCS policies. DHCS is adjusting payments based on proscribed goals. CalOptima's policies should align.

Contracting Criteria

Simplify and streamline processes

48

Recommendations

- Simplify pre-contracting by eliminating RFP process
 - RFP for network participation is atypical and increases administrative cost
 - Develop policies that clarify rationale and basis for adding providers to fill plan needs
 - Current standards for network participation stated in RFP are reasonable. Need for new physician capacity should be emphasized.
- Redesign contracting process
 - Simplify process by making easier for provider to contract.
 - Consider adding key criteria, e.g. percent open panel.
 - Differentiate between contracting criteria and “must pass” standards for delegation of admin functions.
 - Set contract duration based on cost and quality performance.
- Set criteria for bottom quartile corrective actions and duration to correct
 - E.g. if an issue remains uncorrected in three periods, the contract is terminated (provisional contracts).
 - Identify opportunities to work with existing contractors to their performance

Provider Payment Methodologies

Adapt to meet network and financial goals

49

Recommendations

- Continue to utilize all payment models tailored to providers and networks providing flexibility and providers and members choice, e.g. from fee-for-service to shared risk.
- Align payment approach with provider/network experience and integration sophistication, population needs, and CalOptima goals, e.g. bonuses for meeting targets in focused areas of performance improvement.
 - Consider a tiered incentive plan with individual physicians and the networks to incentivize desired outcomes.
 - Move providers/networks toward Value Based Payment plans (within the California constraints) to incentivize quality and reduced costs, share risk, and create alignment between provider and plan goals. Future increases in compensation should be value based.
 - Periodically review approach to high cost services, e.g. high tech radiology and high cost prescriptions. Incorporate incentives for managing utilization of high cost services that are frequent services where the provider/network has a degree of control.
 - Consider including LTC, support services, ILOS/Enhanced Care Management in delegated agreements.
- Incorporate total cost of care in provider reporting to increase transparency and accountability.

Network Protocols

Administrative processes and procedures to support network management

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Recommendations

- Structure network protocols that support Board goals and enable staff to efficiently and effectively conduct network management.
 - ▣ Remove barriers to contracting that add administrative costs, e.g. RFP process and simplify contracting process.
 - ▣ Set clear goals for balance of membership assigned to Health Networks to ensure that at risk Health Networks have sufficient membership to spread risk.
 - ▣ Do not repeat Health Needs Assessment due to limited return on investment and increased risk of provider or member fatigue.
- Establishing Board approved processes and criteria will enable the Board to retain focus on CalOptima's overarching mission, vision, and strategy goals.

Membership Limitation Approach

Panel size and membership

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Recommendations

- Continue no member limit for non-capitated providers.
- 5,000 minimum panel size seems reasonable for risk-based Health Networks.
 - Consideration should be given to keep valuable specialized Health Networks who don't reach required size within a reasonable timeframe to be converted to a non risk-based basis. For example a specialized network for homeless members might need a waiver from the 5,000 limit.
- No network is allowed a super majority of membership.
 - Continue limiting membership as a percent of total, with the top limit of 33% of membership.
 - Consider linking limits to cost and performance outcomes, e.g. better performing networks have a higher percentage of membership.
- Consider limiting the number of Health Networks with which individual providers can contract.
 - Providers in multiple Health Networks add unnecessary complexity.
 - Reaffirm which providers have open panels.

Auto Assignment Considerations

Continue practice to align assignment with higher performing providers

52

Recommendations

- Continue to direct members to higher quality Health Networks using the auto assignment methodology based on HEDIS scores
 - ▣ Share methodology with providers for transparency and accountability
 - ▣ Methodology first designates 45% to the safety net providers. This is consistent with other public plans. Assess definition of Safety Net.
 - ▣ Create tiers for higher assignment for higher performing Health Networks/providers on the basis of financial and quality outcomes
- Consider removing limit on assignment to CCN when over 10% if members continue to choose in significantly high numbers directly contracted physicians and the network maintains quality and cost metrics equal to the other networks
- Monitor to ensure all members are engaged with a PCP
 - ▣ Measure and monitor member retention as a performance indicator
 - ▣ Measure and monitor annual member utilization of their PCP

Network Analytics and Reporting

Reporting financial and outcomes metrics to enhance network performance

53

Recommendations

- Increase transparency with individual network performance comparison data.
 - Report both financial and outcomes in relation to other networks.
 - Provide assistance to reach performance goals, particularly for essential service providers.
 - Include performance metrics and targets in network contracts.
- Analyze data over time to identify trends and opportunities and to revise goals and criteria.
- Ensure that analytics incorporates review of Health Networks and individual provider performance.

Network performance evaluation tool

Develop tools to assist in evaluation in and across Networks

54

Recommendations

- Identify key metrics aligned with CalOptima mission.
 - Limit reviewed metrics to focus on leading and key measures.
 - Develop a holistic, balanced perspective, not just quality focus.
 - Set a target for every key metric.
 - Include NCQA metrics (State considering requiring).
- Leverage currently collected data to reduce administrative burden.
- Increase transparency with individual network performance comparison data compared to other network performance.
- Create multi-level reporting that provides appropriate detail to stakeholders.
- Analyze data over time to identify trends.
- Include performance metrics and targets in network contracts.
- Develop actions based on performance data.

Member Satisfaction

Evaluate survey results for actionable findings

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Recommendations

- Continue current process for member satisfaction survey to meet regulatory requirements.
- Member surveys indicate ongoing concern with access to care.
 - ▣ CalOptima meets regulatory adequacy and access requirements.
 - ▣ Evaluate network strategies, e.g. contracting, incentives, and pre-contracting criteria to address real/perceived access barriers.

Provider Satisfaction

Evaluate survey results for actionable findings

56

Recommendations

- Continue current provider satisfaction survey to meet regulatory requirements.
 - Do not use supplementary surveys.
 - Continue oversight of delegated networks results and actions.
- Network staff lead multi-disciplinary teams to resolve areas of provider dissatisfaction, e.g. all behavioral health measures are low, and a significant decrease in satisfaction with education and training provided.
 - Include Health Networks' staff as necessary.
- Include provider satisfaction goals in Health Network contracts.
 - Network incentives for provider satisfaction goal attainment.
 - Link provider satisfaction to percentage of members assigned to the network.
- Share the survey results with Health Networks for engagement in quality improvement actions.

Administrative Cost Allocation Model

Allocation methodology reflects administrative services

57

Recommendations

- Review allocation methodology to affirm the design is equitable, meaningful, and provides distribution of funds consistent with both retained and delegated administrative functions.
 - ▣ Periodically re-evaluate model to ensure that total administrative expense is consistent with assigned tasks.
- Review current allocation model, adjust to reflect expected costs for actual delegated tasks.
 - ▣ Complete an administrative cost allocation review for each network relative to administrative tasks completed, e.g. delegated tasks versus non-delegated network scope of administrative tasks will vary.
- Consider the administrative cost spend at the delegated provider level.
 - ▣ DHCS is limiting inclusion of capitation expense in RDT where they believe there are administrative costs being passed on to delegate.
 - ▣ CMS is limiting admin cost inclusion in the MLR calculations.

Added Member Health Needs Assessment

A supplemental member needs survey was completed in March 2018

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Recommendations

- Leverage existing tools.
 - State required Group Needs Assessment.
 - HEDIS, CAHPS, and data mining.
- Do not repeat supplemental Member Health Needs Assessment due to limited return on investment and increased risk of provider fatigue.
- Limited use of targeted assessments may be useful for specific populations, e.g. seniors for understanding Long Term Supports and Services needs and barriers.

Caveats

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This presentation is subject to the terms and conditions of the Consulting Services Agreement between CalOptima and Pacific Health Consulting Group (PHCG) dated May 7, 2019.

This presentation has been prepared solely for the internal business use of and is only to be relied upon by the Board and management of CalOptima. These slides are for discussion purposes only. They should not be relied upon without benefit of the discussion that accompanied them.

Thank You

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Appendix

To be included in Final Report

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