NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, NOVEMBER 7, 2019
2:00 P.M.

505 CITY PARKWAY WEST, SUITES 108-109
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Paul Yost, M.D., Chair
Dr. Nikan Khatibi, Vice Chair
Ria Berger
Ron DiLuigi
Supervisor Andrew Do
Alexander Nguyen, M.D.
Lee Penrose
Richard Sanchez
J. Scott Schoeffel
Supervisor Michelle Steel
Supervisor Doug Chaffee, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	INTERIM CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to the Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Board Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. The Board Meeting Agenda and supporting materials are also available online at www.caloptima.org. Board meeting audio is streamed live at https://caloptima.org/en/AboutUs/BoardMeetingsLive.aspx

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

Back to Agenda

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Executive Team Appointments
   b. Be Well OC Groundbreaking
   c. California Advancing and Innovating Medi-Cal (CalAIM)
   d. Value-Based Payment for Behavioral Health Integration
   e. Executive Order on Pharmacy Carve-Out
   f. Healthy California for All Commission
   g. Legislative Hearing on Quality in Medi-Cal Managed Care
   h. OneCare Connect and Medicare Open Enrollment
   i. CalOptima 2020–2022 Strategic Plan
   j. Delivery System Study

PUBLIC COMMENTS

At this time, members of the public may address the Board of Directors on matters not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the October 3, 2019 Regular Meeting of the CalOptima Board of Directors

REPORTS

3. Consider Approval of a Proposed CalOptima Policy and Procedure Related to the CalOptima Program of All-Inclusive Care for the Elderly Program

4. Consider Adopting Resolution Authorizing and Directing Execution of Amendment No. 1 to Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program

5. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract for Enhanced Benefits

6. Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

7. Consider Approval of Homes Health Initiatives Guiding Principles

Back to Agenda

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

10. Consider Authorizing Memorandum of Understanding with the Santa Ana Unified School District to Provide Outreach and Education Services

11. Consider Approval of the Expenditure of Funds to Host a Community Health and Resource Fair for CalOptima Members

12. Consider Authorizing Contract with the Law Firms of Mansfield, Bronstein & Stone, LLP and Solowsky & Allen, P.L. *(to follow Closed Session)* *No action taken*

ADVISORY COMMITTEE UPDATES

13. Member Advisory Committee Update

14. OneCare Connect Member Advisory Update

15. Provider Advisory Committee Update

INFORMATION ITEMS

16. Housing Options in Orange County

17. CalOptima Draft 2020-22 Strategic Plan

18. Hospital Data Sharing Update

19. Health Homes Update

20. September 2019 Financials

21. Compliance Report

Back to Agenda

22. Federal and State Legislative Advocates Reports

23. CalOptima Community Outreach and Program Summary

CLOSED SESSION

CS 1 CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION, Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Government Code section 54956.9: (One Case)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

Back to Agenda

MEMORANDUM

DATE:	October 30, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report — November 7, 2019 Board of Directors Meeting
COPY:	Sharon Dwiers, Interim Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Executive Team Welcomes Chief Financial Officer, Deputy Chief Medical Officer
I am pleased to announce that the CalOptima executive team now includes Nancy Huang and Emily Fonda, M.D., two dedicated leaders who were promoted to higher roles this month. Following a comprehensive search and interviews with external candidates, Ms. Huang was named Chief Financial Officer. As Controller since April 2014, she twice successfully served as CalOptima's Interim Chief Financial Officer (January–October 2017 and February–October 2019). Ms. Huang has a bachelor's degree and MBA from California State University, Fullerton. Moving from Medical Director to Deputy Chief Medical Officer, Dr. Fonda has been a respected member of the Medical Affairs team for almost six years. During that time, she has contributed to many successful initiatives that have enabled CalOptima to maintain our leadership position in Medi-Cal quality. Previously, Dr. Fonda was in private practice for nearly 20 years and held leadership positions with multiple health care organizations, including Hoag Memorial Hospital Presbyterian. She received her medical degree from UC Irvine and earned a Master of Medical Management degree from University of Southern California.

Speakers Celebrate Be Well OC's Promise of Improved Mental Health Care at Groundbreaking Ceremony
On October 16, a large, distinguished group of state and local elected officials and health care leaders assembled for a groundbreaking event at the Be Well OC Regional Mental Health and Wellness Campus in Orange. Sacramento Mayor Darrell Steinberg, co-chair of California's Homeless and Supportive Housing Advisory Task Force and author of the landmark Mental Health Services Act of 2004, spoke, praising Orange County's effort to lead the way in improving mental health care. Tom Insel, M.D., Gov. Gavin Newsom's special advisor on mental health, also shared positive remarks. All five Orange County Supervisors spoke as well. Based on CalOptima's prepayment for services at the Be Well OC campus, I was included among the speakers. I emphasized the value of Be Well OC as an easier-to-access location where Medi-Cal members can receive care with fewer barriers. The 60,000-square-foot facility is scheduled to open in fall 2020.

California Advancing and Innovating Medi-Cal (CalAIM) Initiative Unveiled; Large-Scale Changes to Be Studied by Five Workgroups
On October 28, the Department of Health Care Services (DHCS) unveiled CalAIM. The multiyear initiative is designed to drive broad delivery system, program and payment reforms in Medi-Cal in light of the expiration of the Section 1115 and 1915(b) waivers in 2020. DHCS'

Back to Agenda

announcement said: "CalAIM recognizes the opportunity to provide non-clinical interventions focused on a population health, whole person care approach that targets the social determinants of health and reduces health disparities and inequities in order to improve health outcomes for all Californians." A robust stakeholder engagement process is planned from now until February 2020, working through DHCS' existing advisory committees as well as five new workgroups established for these key CalAIM areas:

CalAIM Area	Workgroup Focus
Population Health Management and Annual Health Plan Open Enrollment	Provide input on the proposal to require Medi-Cal managed care plans to develop and maintain population health management strategies and provide input on the proposal to implement annual Medi-Cal health plan open enrollment.
National Committee for Quality Assurance (NCQA) Accreditation	Provide input on the proposal to require Medi-Cal managed care plans to obtain NCQA accreditation, and offer feedback on the NCQA Medicaid module, the Long-Term Services and Supports Distinction survey, and accreditation deeming policies.
Enhanced Care Management	Provide input on the proposal to implement an enhanced care management benefit statewide and incorporate "in lieu of" services (ILOS) as part of Medi-Cal managed care plan population health management strategies. (ILOS may include recuperative and respite care; long-term assisted living; supplemental personal care services; medically tailored meals; tenancy support and stability services; and minor home repairs, modification and adaptive equipment.)
Behavioral Health	Provide input on the proposal to integrate county-level mental health and substance use disorder (SUD) programs under a single contract; proposed revisions to the medical necessity criteria for behavioral health services; and the possibility of pursuing the Institution for Mental Diseases waiver opportunity. A sub-workgroup will provide input on proposed changes to the reimbursement structure of county-level mental health and SUD services.
Full Integration Pilots	Discuss the full integration of physical health, behavioral health and oral health under one entity.

CalOptima's associations, California Association of Health Plans (CAHP) and Local Health Plans of California (LHPC), will be participating in CalAIM activities through recent staff appointments to four of the five workgroups. I plan to leverage my leadership positions in both organizations to influence CalAIM on behalf of CalOptima.

Health Plans to Have Key Role in Upcoming Behavioral Health Integration (BHI) Projects
Gov. Newsom's FY 2020 budget includes $140 million ($70 million in Proposition 56 funds) for a value-based payment program for BHI. The three-year effort will be implemented through Medi-Cal managed care plans and offer incentive payments to BHI providers for improving care. The goal is to begin delivery system reform through provider-based BHI programs. DHCS is working with CAHP and LHPC on program design, and the intent is to give health plans significant authority. Plans will be responsible for reviewing applications, making award recommendations to DHCS, monitoring project implementation and making payments to providers. Regarding timing, provider applications will be due to health plans by January 21,

2020, and providers will implement their integration projects over two-and-a-half years, through 2022. Once more information is available, CalOptima will begin to develop an Orange County-specific response to this opportunity.

Executive Order on Pharmacy Carve-Out Moving Forward Despite Health Plan Concerns
California will take the next step in carving out pharmacy from Medi-Cal managed care plans by selecting a pharmacy benefit manager (PBM) soon. The state and PBM are expected to execute a contract in November, and the PBM is anticipated to assume some duties on January 1, 2020, in preparation for a January 1, 2021, launch. Stakeholders have requested a delay, given the abbreviated timeframes, but health plan associations warn that it does not seem likely. DHCS' workgroup is continuing to meet regularly to plan for implementation.

Healthy California for All Commission to Study Transition to Single Payer
Gov. Newsom's former Council on Health Care Delivery Systems was recently renamed the Healthy California for All Commission. The responsibilities of the commission have been refocused on exploring a transition to a single payer health care financing system in California. According to the California Health and Human Services Agency, the commission's first report, due July 2020, will analyze California's existing health care delivery system and offer options in preparation for a single-payer system. The second report, due February 2021, will detail key system design considerations, such as eligibility and enrollment, benefits, provider participation and payments, cost containment, governance and administration, information technology investments, and the integration of federal spending on health care in California.

Legislative Hearing to Focus on Medi-Cal Managed Care Quality
On November 4, the Senate and Assembly Health Committees will hold a Joint Informational Hearing regarding Medi-Cal quality. The hearing will address two State Auditor reports published earlier this year. One audit covered children's preventive services, finding that in general, children were not receiving all the Medi-Cal-covered preventive services to which they are entitled. The other audit covered Medi-Cal in regional model counties, which does not impact Orange County.

CalOptima Focuses on OneCare Connect (OCC) During Medicare Enrollment Season
To build awareness of and enrollment in OCC, CalOptima held a member retention/outreach event on October 11 and has two appearances on Vietnamese cable television planned for October 30 and November 13. For the event at the Downtown Anaheim Community Center, CalOptima invited OCC members as well as dual-eligible individuals living within a 6-mile radius. Sixty-six current and prospective members attended. The program consisted of an overview of OCC and 2020 benefits as well as a Q&A session with subject matter experts in customer service, pharmacy, Denti-Cal and other areas. Participants had an opportunity to visit resource tables that featured nearly 20 health networks, vendors, CalOptima departments and community-based organizations. For the October 30 television appearance, I will provide an overview of CalOptima and OCC. On November 13, OneCare Customer Service Supervisor Tammy Nguyen will cover the details of OCC and the 2020 benefits.

Draft of CalOptima's Three-Year Strategic Plan to Come Before the Board in November
CalOptima's draft 2020–2022 Strategic Plan was vetted broadly by numerous stakeholders in October. Chapman Consulting, our Strategic Plan consultant, presented the draft document

Back to Agenda

during a special joint meeting that combined the four Board advisory committees and during a separate session for contracted health networks. On November 7, Chapman Consulting will share the draft plan with the Board for review and feedback. Our intention is to bring a final version to the Board for approval in December, which would be on time for implementation starting January 2020.

CalOptima Adjusts Timing of Delivery System Study to Obtain More Provider Feedback
Work continues on the comprehensive study of CalOptima's health care delivery system, which is being conducted by Pacific Health Consulting Group (PHCG). To date, PHCG has made five public presentations about the study's background and methodology but has not yet shared the analysis or recommendations. Since the study has the potential to affect their organizations, some health networks requested the opportunity to meet individually with PHCG to provide input on the recommendations in advance. Given the importance of our provider partnerships, CalOptima supports this further stakeholder engagement. Therefore, staff is presenting an action item at the November 7 Board meeting to seek authorization and funding for PHCG's additional work. If approved, individual health network meetings will occur in November, and draft study results will be shared with the Board and Provider Advisory Committee in December. PHCG will present the final study in February 2020. While these actions extend the project, ensuring provider involvement now will mean better results and greater acceptance of potential delivery system changes your Board may adopt in the future.

Back to Agenda

CalOptima
A Public Agency
Better. Together.

CEO Report

Presented at November 7, 2019 Meeting

November 7, 2019
Board of Directors Meeting

Michael Schrader
Chief Executive Officer

Back to Agenda

Be Well OC Groundbreaking

- Ceremony took place on October 16
- A large, distinguished group assembled
  - State and local elected officials, including Supervisors Do and Steel
  - Health care leaders, including Richard Sanchez
- CalOptima was highlighted as a participating organization
  - Be Well's model has potential to simplify access to behavioral health care for CalOptima members

Be Well OC/Susan Goldman

Back to Agenda

California Advancing and Innovating Medi-Cal (CalAIM)

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a 174-page proposal that significantly impacts the future Medi-Cal delivery system
  - Spans a five-year period from 2021 to 2025
    - Aligns with waiver renewal
  - Contains more than 20 core initiatives
  - Adds tremendous responsibility to managed care plans, including CalOptima
- Managed care plans are generally supportive of CalAIM

CalAIM Process

- The state's initial CalAIM proposal represents the start of a process
- The ambitious CalAIM proposal will require
  - Stakeholder input
  - CMS approval
    - Federal waiver renewal
    - Federal State Plan Amendment
  - State budget approval
  - State legislation
- The CalAIM proposal is sure to evolve as it goes through these coordination steps before reaching a final form for implementation starting January 1, 2021

CalAIM Impact on CalOptima

- Population health management (PHM)
  - Timeline
    - January 2021
  - Key Details
    - Plans must:
      - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
      - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
      - Conduct initial member assessments and then reassessments on an annual basis
      - Offer basic, complex and enhanced care management

CalAIM Impact on CalOptima (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
  - Replaces Health Homes Program (HHP) and Whole-Person Care (WPC) pilots
  - Timeline
    - July 2020: Transition plan due, showing move from HHP/WPC to ECM/ILOS
    - January 2021: Implementation begins for mandatory populations
  - ECM Key Details
    - Implements ECM to address clinical and non-clinical needs
    - Engages mandatory populations
      - High utilizers
      - Individuals at risk for institutionalization
      - Individuals experiencing chronic homelessness (or at risk of homelessness)
      - Others as identified

CalAIM Impact on CalOptima (Cont.)

- ECM and ILOS (Cont.)
  - ILOS Key Details
    - Allows substitution of one service for another as medically appropriate and cost-effective
    - Deploys services to avoid higher levels of care
  - Menu of ILOS Options (partial list)
    - Housing transition/navigation services
    - Housing deposits
    - Housing tenancy and sustaining services
    - Short-term post-hospitalization housing
    - Recuperative care
  - ILOS Exclusions
    - Room and board
    - Rental costs

CalAIM Impact on CalOptima (Cont.)

- Long-Term Care Integration
  - Timeline
    - January 2023
  - Key Details
    - Eliminates Cal MediConnect (our OneCare Connect program)
    - Requires that all Medi-Cal managed care plans operate Medicare D-SNPS (our OneCare program)

CalAIM Impact on CalOptima (Cont.)

- Regional Rate Setting
  - Timeline
    - Phase 1: Implement January 1, 2021, for targeted counties and plans
    - Phase 2: Fully implement statewide no sooner than January 1, 2023
  - Key Details
    - Shifts development of rates from a county- or plan-based model (e.g., CalOptima) to a regional model (e.g., Southern California)
    - Addresses a workload issue for DHCS
      - It typically takes the state a year or more to establish Medi-Cal rates for all the individual plans
      - CalOptima normally receives final Medi-Cal rates from DHCS after the end of the fiscal year to which they apply

CalAIM Impact on CalOptima (Cont.)

- National Committee for Quality Assurance (NCQA) Accreditation and Deeming
  - Timeline
    - January 2025
  - Key Details
    - Requires that all Medi-Cal managed care plans be NCQA accredited
      - CalOptima is already accredited, but we may need to include a new module for Long-Term Services and Supports
    - Considers requiring NCQA accreditation for all subcontractors/delegated entities (e.g., our health networks)
    - Allows for deeming of certain functions (e.g., credentialing) to avoid overlap/redundancy of NCQA and DHCS audits

CalAIM Impact on CalOptima (Cont.)

- Full Integration
  - Timeline
    - January 2024
  - Key Details
    - Test the effectiveness of full integration of physical health, behavioral health (mental health and substance use disorders) and oral health under one contracted entity

CalAIM Stakeholder Process

- The state has established five workgroups to vet the proposal with stakeholders
  - Meetings are open to the public
  - CalOptima staff are monitoring the meetings
  - CalOptima's associations, California Association of Health Plans (CAHP) and the Local Health Plans of California (LHPC), will participate in the workgroups
    - Through my roles as chair of the CAHP State Programs Committee and chair of LHPC, I will receive weekly updates and provide input as appropriate

Behavioral Health Integration (BHI)

- Current state budget includes $140 million (including $70 million in Proposition 56 funds) for value-based payments for BHI projects in six areas
  - BHI for beginners
  - Maternal mental health and substance abuse
  - Medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses
  - Diabetes screening and treatment for people with serious mental illness
  - Improving follow-up after hospitalization for mental illness
  - Improving follow-up after emergency department visit

BHI (Cont.)

- The initiative is largely structured as a grant program
- Per state guidance, plans will be responsible for
  - Reviewing applications from providers
  - Making award recommendations to DHCS
  - Monitoring project implementation
  - Making payments to providers
- Providers will have 2.5 years to implement BHI projects

Strategic Plan

- Agenda includes presentation of the draft Strategic Plan by Chapman Consulting
- Draft plan was developed with considerable input
  - Individual Board member interviews
  - Full-day strategic planning session for Board
  - Presentation at joint meeting of Board advisory committees
  - Presentation for health networks
- Today's intention is to solicit feedback, make any necessary refinements and bring a final version to your Board in December for approval
- Draft plan is forward-thinking and generally aligned with CalAIM proposal

Delivery System Evaluation

- Action item
  - Authorize an increase in funding for the delivery system evaluation
- Public presentations to date
  - Board of Directors: August 1, August 9 and September 5
  - Provider Advisory Committee: September 12
  - Health networks: September 12
- Provider community request
  - Health networks and hospitals asked for an opportunity to describe their services and functions to consultants, during individual sessions, so that consultants have full understanding of the current delivery system

Delivery System Evaluation (Cont.)

- Timeline adjustments
  - Consultants to present a draft report to the Board on December 5 and the same information to the Provider Advisory Committee the following week
  - Assuming no new or unexpected developments with either Board or stakeholder vetting, consultants to present a final report to the Board in February 2020

Health Homes Program

- Today's agenda includes a presentation about the Health Homes Program (HHP)
  - CalOptima and Orange County Health Care Agency (HCA) have been meeting on a weekly basis regarding HHP
- Proposal
  - CalOptima Community Network to contract with HCA for certain Community-Based Care Management Entity (CB-CME) services related to homelessness/Serious Mental Illness (SMI)
  - Allow health networks the option to also contract with HCA under the same contract template

Health Homes Program (Cont.)

- Next steps
  - HCA and CalOptima to work on developing contract template based on services (not staffing)
    - Contract effective date of April 1, 2020
  - HCA to seek approval from OC Board of Supervisors
  - CalOptima to target February 2020 for Board approval of contract template
- HHP timeline
  - Phase I: January 1, 2020, chronic conditions
    - Q1: CalOptima to focus on member outreach and enrollment
    - Q2: Coordinate with HCA for homeless individuals
  - Phase II: July 1, 2020, SMI
    - Q3: Coordinate with HCA for SMI

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 3, 2019

A Regular Meeting of the CalOptima Board of Directors was held on October 3, 2019, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2.01 p.m. Director Penrose led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger; Ron DiLuigi; Lee Penrose; Richard Sanchez (non-voting) (left meeting at 3:28 p.m.); Scott Schoeffel; Supervisor Andrew Do; Supervisor Michelle Steel

Members Absent: Alexander Nguyen, M.D.

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; David Ramirez, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Sharon Dwiers, Interim Clerk of the Board

Chair Yost reordered the agenda to hear Agenda Item 25, Health Homes Program Update, prior to Agenda Item 14.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Schrader, CEO, highlighted several items from his Report including that CalOptima continues to be one of the top rated Medi-Cal plans in California according to the National Committee on Quality Assurance (NCQA), noting that this year CalOptima received the highest rating along with four other plans including, Alameda Alliance for Health, Community Health Group, San Francisco Health Plan and LA Care Health Plan.

Mr. Schrader provided an update on the next steps regarding CalOptima's strategic planning process, noting that a special joint session that will include all four of the CalOptima Board's advisory committees is scheduled for October 10, 2019, at which consultants from Chapman Consulting will discuss the current health care landscape in relation to the initial areas of focus identified and solicit feedback that will be incorporated into the draft plan being submitted for Board review in November.

In addition, Mr. Schrader also provided an update on the status of the CalOptima healthcare services delivery model evaluation, noting that the provider community has been providing feedback to the consultants from Pacific Health Consulting Group (PHCG) ahead of recommendations being made to the Board. To ensure that stakeholders have ample opportunity to provide input to the consultants, staff may be recommending an expansion of the scope of work in order to allow for additional meetings with the provider community.

Back to Agenda

Mr. Schrader also reported that Richard Figueroa has been named acting director of the California Department of Health Care Services (DHCS), noting that CalOptima will continue to work closely with DHCS as it debuts its new multi-year initiative, California Advancing and Innovating Medi-Cal (CalAIM) program.

PUBLIC COMMENTS

1. Quynh Kieu, M.D. – Oral Re: pediatric reimbursement
2. Samara Cardenas, M.D. – Oral Re: pediatric reimbursement
3. Peter Vu, M.D., Community Pediatrics – Oral Re: pediatric reimbursement
4. Jeffery Flocken, Healthy Smiles for Kids of Orange County Board Member – Oral Re: Agenda Item 12, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funders Towards a Community Grant(s) for Access to Children's Dental Services
5. Richard Munga, DDS, Healthy Smiles for Kids of Orange County Board Member -- Oral Re: Agenda Item 12, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funders Towards a Community Grant(s) for Access to Children's Dental Services
6. Isabel Becerra, Coalition of Orange County Community Health Centers -- Oral Re: Agenda Item 12, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funders Towards a Community Grant(s) for Access to Children's Dental Services
7. Milo Peinemann, American Family Housing, Inc. – Oral Re: Agenda Item 16, Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the September 5, 2019 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the August 8, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Appointments of OneCare Connect Member Advisory Committee Chair and Vice Chair

4. Consider Adopting Resolution No. 19-1003-01 Amending Resolution No. 12-0301-01 to Amend CalOptima Policy GA.3202: CalOptima Signature Authority

5. Consider Authorizing the Issuance of a Request for Proposal(s) for CalOptima Real Estate Related Services

6. Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating and Capital Budgets for Various Information Services Items

7. Consider Authorizing Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2020

8. Consider Approval of Reappointments to the Board of Directors' Investment Advisory Committee

Back to Agenda

9. Consider Revising the Membership of the CalOptima Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 7-0-1; Supervisor Do abstained on Agenda Item 7)***

REPORTS

10. Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Audited Financial Statements

As Chair of the Board of Directors' Finance and Audit Committee, Director Penrose reported that the Committee reviewed the audited financial statements for the fiscal year ending June 30, 2019 at the September 19, 2019 meeting, and introduced Stacy Stelzriede of Moss-Adams, LLP, CalOptima's independent financial auditor, who presented a brief overview of the audited financials.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors accepted and received and filed the Fiscal Year (FY) 2019 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP. (Motion carried 8-0-0)***

11. **Acting as the CalOptima Foundation:** Consider Accepting and Receiving and Filing the Fiscal Year 2019 CalOptima Foundation Audited Financial Statements

Director Penrose reported that the Foundation Audit Committee met on September 19, 2019 to review the audited financial statements for the fiscal year ending June 30, 2019, and recommended that the Foundation Board of Directors accept and receive and file the audited financial statements as submitted by independent auditors Moss-Adams, LLP. He also noted that with the Foundation wind down nearly complete, all remaining assets have been transferred back to CalOptima, and that these will be the final financial statements for the CalOptima Foundation.

Action: ***On motion of Director Penrose, seconded and carried, the Foundation Board of Directors accepted and received and filed the Fiscal Year 2019 CalOptima Foundation audited financial statements as submitted by independent auditors Moss-Adams, LLP. (Motion carried 8-0-0)***

12. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funders Towards a Community Grant(s) for Access to Children's Dental Services

Director Berger did not participate in this item due to conflicts of interest based on her affiliation with Healthy Smiles for Kids Orange County, which is a responder to this RFP, and left the room during the discussion and vote.

Candice Gomez, Executive Director, Business Implementation, presented an overview of the request for proposal (RFP), and reviewed the evaluation criteria, scoring sheets, and other materials requested by the Board related to the grant allocation for Access to Children's Dental Services. Ms. Gomez referenced and made available copies of Attachment 9, IGT 5 Community Grant Application

Back to Agenda

Summary, which had been included in the September 5th Board materials, but had inadvertently been left out of the packet prepared for today's meeting. Ms. Gomez reiterated that the IGT ad hoc had directed staff to reach out to the two finalists on the issue of whether they would be able to meet the commitments proposed in their respective RFP responses even if they were to be awarded a lower funding amount than they had requested. The responses from both finalists were that they would not be able to meet the stated objectives in the proposals unless they received their full requested funding amounts. However, the Coalition of Orange County Community Health Centers subsequently advised staff that it had received additional outside funding to supplement its proposal and Healthy Smiles for Kids of Orange County subsequently indicated to staff that it would be able to scale its proposal if it received reduced funding. After considerable discussion, the Board took the following action.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors 1) Awarded IGT 5 funds in the amount up to ~~$1 million~~ $500,000 to the Coalition of Orange County Community Health Centers and up to $500,000 to Healthy Smiles for Kids of Orange County ~~for a~~ for community ~~grant(s)~~ grants for Access to Children's Dental Services; and 2) Authorized the Chief Executive Officer with the assistance of Legal Counsel, to execute grant ~~contract(s)~~ contracts with the selected community ~~grantee(s)~~ grantees. (Motion carried 7-0-0; Director Berger recused)***

Chair Yost announced that Agenda Item 13 would be considered in two separate actions due to potential Board Member conflicts.

13. Consider Authorizing Supplemental Payments to Health Networks for Specific Home Health Agency Services

a. The first action is to consider authorizing supplemental payments exclusively to health networks associated with AltaMed Health Services Corporation for specific home health agency services.

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do and Supervisor Steel did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1) Authorized the Chief Executive Officer (CEO) to make supplemental payments for specific home health agency services to health networks associated with AltaMed Health Services Corporation from July 1, 2018, through June 30, 2019; 2) Approved disbursement methodology for these supplemental payments; 3) Made a finding that such expenditures are for a public purpose; and 4) Authorized the CEO to execute agreements and/or contract amendments as necessary for implementation (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Supervisor Steel recused)***

b. The second action is to consider authorizing supplemental payments to all health networks except those associated with AltaMed Health Services Corporation for specific home health agency services.

Back to Agenda

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Chair Yost did not participate in this item due to potential conflicts of interest based on his role as a physician anesthesiologist with CHOC. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1) Authorized the Chief Executive Officer (CEO) to make supplemental payments for specific home health agency services to health networks except those associated with AltaMed Health Services Corporation from July 1, 2018, through June 30, 2019; 2) Approved disbursement methodology for these supplemental payments; 3) Made a finding that such expenditures are for a public purpose; and 4) Authorized the CEO to execute agreements and/or contract amendments as necessary for implementation (Motion carried 5-0-1; Director Schoeffel absent; Chair Yost recused; Supervisor Do abstained)***

INFORMATION ITEMS

25. Health Homes Program Update

Candice Gomez, Executive Director, Program Implementation, Tracy Hitzeman, Executive Director, Clinical Outcomes and TC Roady, Director Regulatory Affairs and Compliance, presented an update on the Health Homes Program. The Board directed staff to continue to provide updates on the program as well as on and any additional guidance provided by the Department of Health Care Services related to the program.

REPORTS

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Chair Yost did not participate in this item due to potential conflicts of interest based on his role as a physician anesthesiologist for CHOC. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1) Authorized the Chief Executive Officer, with the assistance of Legal Counsel to: a) Amend the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as including all subcontracting requirements of the California Department of Health Care Services (DHCS); b) Amend the Business Associate Agreements, as necessary, for network data sharing; and 2) Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima***

members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019. (Motion carried 5-0-1; Director Schoeffel absent; Chair Yost recused; Supervisor Do abstained)

15. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Associated with AltaMed Health Services Corporation to include language for the Health Homes Program

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do and Supervisor Steel did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to Amend the CalOptima Medi-Cal Health Network Contracts associated with AltaMed Health Services Corporation to provide Health Homes Program (HHP) services including responsibilities as Community Based-Care Management Entities (CB-CMEs). (Motion carried 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Supervisor Steel recused)***

16. Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services.

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Vice Chair Khatibi did not participate in this item due to potential conflicts of interest based on his role serving on the Illumination Foundation Board of Directors.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors 1) Approved recommended vendor Illumination Foundation for HHP select services for accompaniment and housing related services; 2) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with the recommended vendor, effective January 1, 2020; and 3) In the event CalOptima and Illumination Foundation are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Maxim Healthcare Services, for HHP select services for accompaniment and housing related services. (Motion carried 6-0-0; Director Schoeffel absent; Vice Chair Khatibi recused)***

17. Consider Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors 1) Reappointed the following individuals as Family Members on the Whole-Child Model Family Advisory Committee: a) Malissa Watson for a two-year term ending June 30, 2021; b) Pamela Patterson for a term ending November 30, 2019. 2) Reappointed the following individual as Community Representative: a) Sandra Cortez-Schultz for a term ending June 30, 2021. 3) New Appointment of the following individual as a Family Member: a) Brenda***

Deeley for a term ending June 30, 2021. 4) New Appointment of the following individual as a Consumer Advocate: a) Kathleen Lear for a term ending June 30, 2021. (Motion carried; 8-0-0)

18. Consider Authorizing and directing Execution of the Cal-MediConnect Three-Way Agreement Between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized and directed the Chairman of the Board of Directors to execute a new three-way agreement (Agreement) between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services for the Cal MediConnect Program that incorporates an extension of the program for additional Demonstration Years (DY) 6 through 8, new provisions and other regulatory updates. (Motion carried; 8-0-0)***

19. Consider Authorizing Amendments to the OneCare Physician Medical Group Shared Risk Contracts

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Do and Supervisor Steel did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Shared Risk Physician Medical Group (PMG) Contracts with AltaMed Health Services Corporation, AMVI/Prospect Medical Group, ARTA Western California Inc., Talbert Medical Group, Family Choice Medical Group Inc., Monarch Health Plan Inc., Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Talbert Medical Group P.C., and United Care Medical Group Inc. to: 1) Extend the term of the PMG Contracts through December 31, 2020; and 2) Include language related to the Merit-based Incentive Payments System (MIPS) program. (Motion carried; 5-0-1; Director Schoeffel absent; Supervisor Do abstained; Supervisor Steel recused)***

20. Consider Modifications to CalOptima Quality Improvement Policies and Procedures Related to Annual Policy Review

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO) to modify existing Policies and Procedures, as follows: 1) GG.1607: Monitoring Adverse Actions; 2) GG.1608: Full Scope Site Reviews; 3) GG.1620: Quality Improvement Committee; and 4) GG.1639: Post-Hospital Discharge Medication Supply. (Motion carried; 8-0-0)***

Back to Agenda

21. Consider Approval of Modifications of CalOptima Policies and Procedures Related to CalOptima's Whole-Child Model Program and Merit-based Incentive Payment System (MIPS) Payment Adjustment

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors Approved modifications to the following Policies and Procedures: A) GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program [Medi-Cal]; B) GG.1318: Coordination of Care for Hemophilia Members [Medi-Cal]; C) GG.1539: Authorization for Out-of-Network and Out-of-Area Services [MC, OC, OCC]; D) MA.3101: Claims Processing [OC, OCC, PACE]. (Motion carried; 8-0-0)***

22. Consider Authorizing Unbudgeted Operating Expenditures For Royalty Fees For Use Of The American Medical Association Current Procedural Terminology Codes

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors Authorized unbudgeted Operating expenditures and appropriated the funds within the Medi-Cal program administrative expenses category in an additional amount not to exceed $30,000 from existing reserves for an increase to Other Operating Expenses-Software Maintenance for royalty fees for use of the American Medical Association (AMA) Current Procedural Terminology (CPT) codes. (Motion carried; 8-0-0)***

ADVISORY COMMITTEE UPDATES

23. OneCare Connect Member Advisory Committee Update

Patty Mouton, OCC MAC Chair, thanked the Board for approving OCC MAC Chair and Vice Chair appointments and provided a brief overview of the Special OCC MAC meeting held on August 22, 2019.

24. Provider Advisory Committee Update

John Nishimoto, PAC Chair, noted that the PAC's report is included in the Board materials and thanked the Board on behalf of the PAC for the opportunity to review and comment on the health network delivery system.

INFORMATION ITEMS

25. Health Homes Program Update

This item was heard prior to Agenda Item 14.

The following Information Items were accepted as presented:

26. August Financials
27. Compliance Report
28. Federal and State Legislative Advocates Report
29. CalOptima Community Outreach and Program Summary

Back to Agenda

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Penrose thanked Victor Hausmaninger for his service on the CalOptima Foundation Audit Committee.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:21 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Interim Clerk of the Board

Approved: 11/7/2019

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Approval of a Proposed CalOptima Policy and Procedure Related to the CalOptima Program of All-Inclusive Care for the Elderly Program

Contact

David Ramirez, M.D. Chief Medical Officer, (714)246-8400

Recommended Action

Approve the following Policy and Procedure related to the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Program:

A. PA.7100: Premium & Share of Cost Collection [PACE]

Background/Discussion

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve functional status of the program's participants. CalOptima PACE currently serves 357 members via the CalOptima PACE center and five alternative care setting sites.

Under Title 42 of the Code of Federal Regulation section 460.150(d), *eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or a Medicaid beneficiary*. Additional regulatory and contractual language provide further guidance on eligibility and premium determination that allow for an individual to pay privately to participate in the PACE program. Nationally, less than 1% of PACE enrollees are required to pay a premium to be enrolled in a PACE program. Currently, no CalOptima PACE participants are required to pay a premium for enrollment because of their eligibility for Medi-Cal and/or Medicare. Though not considered a premium, Medi-Cal share of cost obligations are also payments made by members to CalOptima, to be or remain, enrolled in CalOptima PACE.

The proposed policy establishes a framework for determining, communicating, collecting, and monitoring collection of participant private pay premiums and share of cost. Additionally, the proposed policy defines Installment Plan Agreements and addresses failure to pay procedures in coordination with PA.2021 Involuntary Disenrollment.

Fiscal Impact

The recommended action to approve CalOptima Policy PA.7100: Premium & Share of Cost Collection [PACE] is budget neutral. The collection of PACE participants' share of cost is an existing process and is accounted for in the CalOptima Fiscal Year 2019-20 Operating Budget. CalOptima is projected to collect approximately $20,000 annually in share of cost payments. The actual amount may vary depending on the number of participants with share of cost. There is no additional fiscal impact.

Back to Agenda

Currently, PACE is comprised of Medi-Cal only and dually eligible enrolled members. In the event CalOptima collects premium for members who are Medicare only, or non-Medicare and non-Medi-Cal, Staff anticipates the fiscal impact to be revenue neutral as these members would be responsible for the premium shortfall.

Rationale for Recommendation

To establish a process to meet regulatory and contractual requirements related to premium and share of cost collection, approval of the requested action is recommended.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PA.7100: Premium & Share of Cost Collection [PACE] PRC-Approved
2. Title 42 of the Code of Federal Regulation section 460.150(d)

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

Back to Agenda

Policy:	PA.7100PP
Title:	**Premium & Share of Cost Collection**
Department:	PACE
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	11/07/2019
Revised Date:	Not Applicable

I. PURPOSE

This policy establishes the processes for determining and collecting **Premiums*** and **Share of Cost** associated with the CalOptima Program of All-Inclusive Care for the Elderly (PACE) program.

II. POLICY

A. **Participants** enrolled in CalOptima PACE shall be charged a monthly **Share of Cost** when they have a **Share of Cost** obligation that must be met prior to being eligible for Medi-Cal.

B. **Participants** shall be notified of changes to the **Premium** amount in writing at least thirty (30) calendar days before the change takes effect.

C. **Premiums** and **Share of Cost** are due the first day of the month for which services will be received. Late fees may be assessed in accordance with the **Enrollment Agreement**.

D. **Participants** failing to pay the monthly **Premium** or **Share of Cost** may be involuntarily disenrolled in accordance with CalOptima Policy PA.2021: Involuntary Disenrollment.

E. **Participants** with **Premium** or **Share of Cost** obligations may request an **Installment Plan Agreement**. **Installment Plan Agreements** are valid when mutually agreed upon by the **Participant** and the CalOptima Chief Financial Officer, with a signed, written agreement.

1. **Installment Plan Agreements** are only available in situations in which the **Participant** is unable to make a single monthly payment due to an unforeseen circumstance. The effect of the circumstance will be limited to a single monthly payment and the **Participant** will be able to pay the combined monthly payment plus installment payment thereafter.

III. PROCEDURE

A. Determining **Participant Share of Cost**

1. CalOptima PACE shall access the Medi-Cal eligibility verification system to determine if a **Participant** must pay a **Share of Cost**.

B. Determining and Communicating **Participant Premiums**

Participant	**Premium**
Entitled to Medicare Part A, enrolled in Medicare Part B, and enrolled in Medi-Call	No premium*

***** Terms in **bold** are defined in the Glossary.

Back to Agenda

Not entitled to Medicare Part A, not enrolled in Medicare Part B, enrolled in Medi-Cal	No premium*
Entitled to Medicare Part A, not enrolled in Medicare Part B, enrolled in Medi-Cal	No premium*
Entitled to Medicare Part A, not enrolled in Medicare Part B, not enrolled in Medi-Cal	Medi-Cal Capitation + Medicare Part B capitation rate + Medicare Part D Premium
Entitled to Medicare Part A, enrolled in Medicare Part B, not enrolled in Medi-Cal	Medi-Cal capitation amount + Medicare Part D premium**
Not Entitled to Medicare Part A, enrolled in Medicare Part B, not enrolled in Medi-Cal	Medicare Part A capitation rate + Medi-Cal capitation amount + Medicare Part D premium**
Not entitled to Medicare Part A, not enrolled in Medicare Part B, not enrolled in Medi-Cal	Medicare Part A capitation rate + Medicare Part B capitation rate + Medicare Part D premium + Medi-Cal capitation amount

* Medi-Cal **Share of Cost Participants** are responsible for their **Share of Cost** obligation.

** Note that the **Premium** is for the PACE benefit only. The **Participant** must continue to pay Part B premiums to Medicare.

1. **Participant** Notification of **Premiums**

   a. During the **Participant** intake process, the Manager, Marketing and Enrollment, confirms if a **Premium** or **Share of Cost** obligation is required, based on current status of eligibility for:

      i. Medi-Cal; and

      ii. Medicare.

   b. The Manager, Marketing and Enrollment identifies the **Premium** or **Share of Cost** amount

      i. The **Premium** or **Share of Cost** amount, if any, is written in the **Enrollment Agreement** prior to the prospective **Participant** being asked to sign the **Enrollment Agreement** and is reviewed with the prospective **Participant** during the **Enrollment Conference** by the designated PACE representative.

   c. **Premium** or **Share of Cost** Changes

      i. At a minimum, **Participants** will be notified of changes to **Premiums** annually. **Premium** changes must be in writing and dated at least thirty (30) calendar days before the change takes effect.

      ii. Notification to **Participants** of changes to **Share of Cost** amount is communicated by the County of Orange Social Services Agency.

C. Collecting **Premiums** and **Share of Cost**

1. Accounting will generate a monthly invoice based on a list provided by PACE. The invoice will include:

   a. Amount due;

   b. Date of service month;

c. Due date of payment;

d. Reference to any amount past due; and

e. Notice advising **Participants** that failure to pay may result in involuntary disenrollment.

D. Monitoring Collection

1. Accounting will provide PACE with a report monthly, or upon request, of outstanding balances and days past due as a tracking tool.

2. The PACE Center Manager or their **Designee** will monitor the tracking tool to initiate the involuntary disenrollment process, as described in CalOptima Policy PA.2021: Involuntary Disenrollment for **Participants** who do not resolve their balance.

3. Payments made to CalOptima PACE must be mailed to the remittance address on the invoice. CalOptima PACE staff do not accept payment but may assist in providing a remittance envelope.

4. If a **Participant** is voluntarily or involuntarily disenrolled from CalOptima PACE, the PACE Program Specialist will notify Accounting prior to the next invoicing period.

5. If a **Participant** with a past due balance disenrolls from CalOptima PACE, staff will evaluate all available legal recourse to collect the remaining balance prior to moving the balance to uncollectable.

6. **Participants** with **Share of Cost** or **Premium** obligations may request an **Installment Plan Agreement**. Eligibility for **Installment Plan Agreements** shall be evaluated in accordance with Section II.G of this policy.

   a. **Installment Plan Agreement** requests may be made in writing, email, or mailed addressed to the PACE Center, or verbally to the PACE Program Director. If the **Participant** makes a verbal request, the Participant's request is submitted by the PACE Director, in writing, to the Chief Financial Officer.

      i. If an **Installment Plan Agreement** is approved for a **Share of Cost** obligation, the concept of obligating **Share of Cost** is met.

   b. The Chief Financial Officer or **Designee** has authority to approve **Installment Plan Agreements**.

      i. Monthly installment payment must be at least ten percent (10%) of past due balances plus current month's **Premium**, and

      ii. If the installment payment is not received within fifteen (15) calendar days of the established due date, the total balance is due immediately. Late installment payments will result in initiation of the involuntary disenrollment process for failure to pay **Premium** or **Share of Cost**.

      iii. In the event of unexpected financial hardship, CalOptima may review other installment plan options for **Participants**.

a) The **Participan**t may submit a financial hardship installment plan request in writing or verbally to the PACE Director.

b) All financial hardship installment plan requests shall be reviewed by the CFO in compliance with the Medicare installment plan criteria.

c) A decision shall be rendered no later than the DHCS disenrollment cut-off date, every capitation month, for all financial hardship installment plan requests received within the past thirty (30) calendar days.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima PACE Program Agreement (CalOptima and CMS PACE Program Agreement, No. H7501), Appendix M: Medicare and Medicaid Payment Amounts
B. CalOptima PACE Participant Enrollment Agreement Terms and Conditions: Chapter 9 - Monthly Fees, Prepayment Fees
C. CalOptima Policy PA.2021: Involuntary Disenrollment
D. CMS PACE Manual: Chapter 13 – Payments to PACE Organizations, §40.3 PACE Premiums: Premiums for Persons who are Medicare Eligible
E. Title 42, Code of Federal Regulations §460.186
F. Tri-fold Brochure, Material ID H7501_19MM01_M Approved (12/14/18)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/07/2019	PA.7100PP	Premium and Share of Cost Collection	PACE

IX. GLOSSARY

Term	Definition
Designee	CalOptima employee authorized to perform a task on behalf of a supervisor.
Enrollment Agreement	Refers to the Participant Enrollment Agreement Terms and Conditions and the PACE Benefits Coverage Packet document that is signed by the prospective Participant to enroll in the CalOptima PACE program.
Enrollment Conference	The in-person meeting where a CalOptima PACE representative reviews the terms and conditions with the prospective PACE participant. To enroll in CalOptima PACE, the prospective participant signs the Benefits and Coverage Signature Pages.
Installment Plan Agreement	A signed, written agreement where the Participant and CalOptima Chief Financial Officer mutually agree upon a time-limited repayment plan for owed Premium or Share of Cost obligation.
Participant	An individual enrolled in the CalOptima PACE program.
Premium	The amount that a PACE organization can charge a Participant as a monthly premium depending on the Participant's eligibility under Medicare and Medicaid/Medi-Cal.
Share of Cost	The amount some Medi-Cal beneficiaries must pay, or agree to pay, on a monthly basis towards their medical expenses before they qualify for Medi-Cal benefits.

(i) Physiological well being.
(ii) Functional status.
(iii) Cognitive ability.
(iv) Social/behavioral functioning.
(v) Quality of life of participants.

(4) Effectiveness and safety of staff-provided and contracted services, including the following:
(i) Competency of clinical staff.
(ii) Promptness of service delivery.
(iii) Achievement of treatment goals and measurable outcomes.

(5) Nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

(b) *Basis for outcome measures.* Outcome measures must be based on current clinical practice guidelines and professional practice standards applicable to the care of PACE participants.

(c) *Minimum levels of performance.* The PACE organization must meet or exceed minimum levels of performance, established by CMS and the State administering agency, on standardized quality measures, such as influenza immunization rates, which are specified in the PACE program agreement.

(d) *Accuracy of data.* The PACE organization must ensure that all data used for outcome monitoring are accurate and complete.

§ 460.136 Internal quality assessment and performance improvement activities.

(a) *Quality assessment and performance improvement requirements.* A PACE organization must do the following:

(1) Use a set of outcome measures to identify areas of good or problematic performance.

(2) Take actions targeted at maintaining or improving care based on outcome measures.

(3) Incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time.

(4) Set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes.

(5) Immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE participant.

(b) *Quality assessment and performance improvement coordinator.* A PACE organization must designate an individual to coordinate and oversee implementation of quality assessment and performance improvement activities.

(c) *Involvement in quality assessment and performance improvement activities.* (1) A PACE organization must ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.

(2) The quality improvement coordinator must encourage a PACE participant and his or her caregivers to be involved in quality assessment and performance improvement activities, including providing information about their satisfaction with services.

§ 460.138 Committees with community input.

A PACE organization must establish one or more committees, with community input, to do the following:

(a) Evaluate data collected pertaining to quality outcome measures.

(b) Address the implementation of, and results from, the quality assessment and performance improvement plan.

(c) Provide input related to ethical decisionmaking, including end-of-life issues and implementation of the Patient Self-Determination Act.

§ 460.140 Additional quality assessment activities.

A PACE organization must meet external quality assessment and reporting requirements, as specified by CMS or the State administering agency, in accordance with § 460.202.

Subpart I—Participant Enrollment and Disenrollment

§ 460.150 Eligibility to enroll in a PACE program.

(a) *General rule.* To enroll in a PACE program, an individual must meet eligibility requirements specified in this section. To continue to be eligible for

PACE, an individual must meet the annual recertification requirements specified in § 460.160.

(b) *Basic eligibility requirements.* To be eligible to enroll in PACE, an individual must meet the following requirements:

(1) Be 55 years of age or older.

(2) Be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs.

(3) Reside in the service area of the PACE organization.

(4) Meet any additional program specific eligibility conditions imposed under the PACE program agreement. These additional conditions may not modify the requirements of paragraph (b)(1) through (b)(3) of this section.

(c) *Other eligibility requirements.* (1) At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

(2) The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting must be specified in the program agreement.

(d) *Eligibility under Medicare and Medicaid.* Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. A potential PACE enrollee may be, but is not required to be, any or all of the following:

(1) Entitled to Medicare Part A.

(2) Enrolled under Medicare Part B.

(3) Eligible for Medicaid.

§ 460.152 Enrollment process.

(a) *Intake process.* Intake is an intensive process during which PACE staff members make one or more visits to a potential participant's place of residence and the potential participant makes one or more visits to the PACE center. At a minimum, the intake process must include the following activities:

(1) The PACE staff must explain to the potential participant and his or her representative or caregiver the following information:

(i) The PACE program, using a copy of the enrollment agreement described in § 460.154, specifically references the elements of the agreement including but not limited to § 460.154(e), (i) through (m), and (r).

(ii) The requirement that the PACE organization would be the participant's sole service provider and clarification that the PACE organization guarantees access to services, but not to a specific provider.

(iii) A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers under § 460.70(c).

(iv) Monthly premiums, if any.

(v) Any Medicaid spenddown obligations.

(vi) Post-eligibility treatment of income.

(2) The potential participant must sign a release to allow the PACE organization to obtain his or her medical and financial information and eligibility status for Medicare and Medicaid.

(3) The State administering agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs.

(4) PACE staff must assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility specified in this part.

(b) *Denial of Enrollment.* If a prospective participant is denied enrollment because his or her health or safety would be jeopardized by living in a community setting, the PACE organization must meet the following requirements:

(1) Notify the individual in writing of the reason for the denial.

(2) Refer the individual to alternative services, as appropriate.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Adopting Resolution Authorizing and Directing Execution of Amendment No. 1 to Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Adopt Board Resolution No. 19-1107-01, authorizing and directing the Chairman of the Board to execute Amendment No. 1 to Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2019-20.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past eighteen (18) years. Currently, CalOptima serves 446-460 clients each month. Most recently, on June 6, 2019, the Board of Directors adopted Resolution No. 19-0606-01 authorizing CalOptima to enter in contract MS-19-20-41 with the CDA for the MSSP.

Discussion

For the first time in over 13 years, the State provided a budget augmentation for CalOptima's MSSP retroactively for Fiscal Year 2019-2020 with recently passed legislation.

The scope of work and other obligations remains consistent with existing contract obligations. However, the CDA requires documentation in the form of a resolution, order, or motion by the governing board for the original and each subsequent amendment to the contract.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now operates within CalOptima's Long Term Services and Supports (LTSS) Department. The payment structure from DHCS for the MSSP program transitioned from fee-for-service with advance payments to

Back to Agenda

a CCI payment model following CCI integration. Under the CCI model, DHCS provides CalOptima with Medi-Cal revenue for the MSSP by accounting for MSSP members in the established capitation rate setting process.

Fiscal Impact

The recommended action to amend contract MS-19-20-41 for the MSSP is a budgeted item and included in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. Since 2015, DHCS has included the MSSP in Medi-Cal capitation rate development. Amendment No. 1 increases MSSP program allocation by $487,396. As such, the fiscal impact is budget neutral and will result in an increase to indirect allocation within the Medi-Cal line of business.

Rationale for Recommendation

Adoption of Board Resolution No. 19-1107-01, authorizing and directing the Chairman of the Board of Directors to execute the FY 2019-20 contract amendment with the CDA for MSSP, is required by the CDA, and will provide additional resources to allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Board Resolution No. 19-1107-01, Execute Amendment No. 1 to Contract No. MS-19-20-41 with the State of California Department of Aging for the Multipurpose Senior Services Program.
2. Board Action dated June 6, 2019 Adopt Resolution Authorize Execution of CDA Contract MS-19-20-41 MSSP

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 19-1107-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE AMENDMENT 1 TO CONTRACT NO. MS-19-20-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of up to 460 MSSP participant slots to CalOptima; and,

WHEREAS, on June 6, 2019, the Board of Directors adopted Resolution No. 19-0606-01 authorizing CalOptima to enter into Contract MS-19-20-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to the Board of Directors; and,

WHEREAS, the State of California provided a budget augmentation for CalOptima's MSSP retroactively for Fiscal Year 2019-2020; and

WHEREAS, the California Department of Aging requires a Resolution approved by the Board of Directors for each subsequent amendment to its contract, and has requested the execution of Amendment 1 to Contract MS-19-20-41; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing Amendment 1 to Contract MS-19-20-41.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into Amendment 1 to Contract MS-19-20-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver Amendment 1 to Contract MS 19-20-41 by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of November 2019.

AYES:

NOES:

ABSENT:

ABSTAIN:

Back to Agenda

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Interim Clerk of the Board

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Adopting Resolution Authorizing and Directing Execution of Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Adopt Board Resolution No. 19-0606-01, authorizing and directing the Chairman of the Board to execute Contract MS-19-20-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2019-20.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past eighteen (18) years for up to a maximum of 568 members at any given point in time. Currently, CalOptima serves 446-460 clients.

Discussion

CalOptima has received CDA Contract MS-19-20-41 for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract will extend the MSSP program through June 30, 2020, with the maximum amount of the contract set at $1,949,675.

The scope of work and other obligations are consistent with existing contract obligations. In addition to primarily wording and technical revisions, there are some proposed clarifications regarding the content of future audits and the responsibility of CalOptima MSSP in these audits. These responsibilities include cooperating with authorized representatives of federal or State government and inserting contract language with independent audit firms to ensure audit documents are made available

Back to Agenda

if requested. There is also a proposed language revision to indicate expenditures should be reconciled to the total budget allocation.

Staff does not anticipate that any of these changes will have a significant operational or financial impact as they are largely already in operation.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now operates within CalOptima's Long Term Services and Supports (LTSS) Department. The payment structure from DHCS for the MSSP program transitioned from fee-for-service with advance payments to a CCI payment model following CCI integration. Some of the attached contract language referring to non-CCI models may therefore not apply. Under the CCI payment model, DHCS provides CalOptima with Medi-Cal revenue for the MSSP program by accounting for MSSP members in the established capitation rate setting process.

Fiscal Impact
Revenues and expenses associated with the MSSP program are budgeted items and are included in the proposed CalOptima Fiscal Year (FY) 2019-20 Operating Budget pending Board approval.

Rationale for Recommendation
Adoption of Board Resolution No. 19-0606-01, authorizing and directing the Chairman of the Board of Directors to execute the FY 2019-20 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Resolution No.19-0606-01, Execute Contract No. MS-19-20-41 with the State of California Department of Aging for the Multipurpose Senior Services Program

/s/ Michael Schrader — *5/29/2019*
Authorized Signature — **Date**

Back to Agenda

RESOLUTION NO. 19-0606-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT NO. MS-19-20-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of up to 460 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-19-20-41; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-19-20-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 6th day of June 2019.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Interim Clerk of the Board

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment to the Vision Service Plan HMO Services Contract for Enhanced Benefits

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Vision Service Plan (VSP) HMO Services Contract for OneCare (OC) and OneCare Connect (OCC) to reflect the additional frame and contact lens benefit allowance for members.

Background/Discussion

VSP has been CalOptima's vision services provider since January 1, 2007. The current contract, which was the result of a CalOptima Board of Directors authorized Request for Proposal (RFP) for vision services, has been in effect since July 1, 2016. An RFP was issued on September 3, 2015, for a new vision contract effective July 1, 2016, containing Medi-Cal, OneCare, OneCare Connect and PACE terms and conditions. VSP was awarded the new contract for both CalOptima's Medi-Cal and Medicare programs.

For OneCare and OneCare Connect the VSP contract financial terms include a biennial frame and lens benefit of $250 per member. For 2020, this benefit allowance amount has increased to $300, and management is seeking authority to update the contract to reflect this change effective January 1, 2020.

Staff recommends that the Board authorize an amendment to the VSP HMO services contract to ensure that it reflects the 2020 OneCare and OneCare Connect additional benefit allowance.

Fiscal Impact

The annual fiscal impact to increase the biennial frame and lens benefit allowance amount from $250 to $300 is approximately $120,000 for OCC and $14,000 for OC. The fiscal impact from the effective date of January 1, 2020, through June 30, 2020, is approximately $67,000 and is a budgeted item under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. Management will include the revised vision services benefit expenses in future operating budgets.

Rationale for Recommendation

Approval of the VSP contract amendment is necessary to update the terms to address the increased biennial frame and lens benefit amount for OneCare and OneCare Connect effective January 1, 2020.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Entities covered by this recommended Board Action
2. Board Action dated September 3, 2015, Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs.

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

Back to Agenda

Attachment to November 7, 2019 Board of Directors Meeting – Agenda Item 5

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Vision Service Plan (VSP)	3333 Quality Drive	Rancho Cordova	CA	92602

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. G. Authorize Request for Proposal Process for Vision Service Vendor(s) Effective July 1, 2016 for Medi-Cal, OneCare, OneCare Connect, and PACE Programs

Contact
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to issue a Request for Proposal (RFP) for Vision Service vendor(s) and contract with the selected vendor effective July 1, 2016 through June 30, 2019, with two one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion
Vision services are a required benefit for Medi-Cal, OneCare Connect (OCC), OneCare (OC) and PACE members. CalOptima has been contracted with VSP since 2009 for services to OneCare and Medi-Cal members as a result of an RFP process conducted in 2008. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OC provider network and use it as the foundation for the Duals Delivery system. Based on this authority, the existing OC contracts were amended to also apply to OCC. The current vision services vendor contract expires on June 30, 2016, based on the previous contract extensions.

As indicated, VSP has been the sole vision provider contracted with CalOptima since 2009 as a result of an RFP released in 2008. In accordance with vendor management best practices, staff recommends completing a new RFP process which will be effective July 1, 2016.

Fiscal Impact
The recommended action is budget neutral.

Rationale for Recommendation
CalOptima staff recommends authorizing issuance of an RFP and selection of a vendor(s) effective July 1, 2016 to ensure that members continue to have access to vision services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/28/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Pacific Health Consulting Group (PHCG) to include additional work related to the evaluation of the CalOptima provider network delivery system; and
2. Authorize additional expenditures on this engagement of unbudgeted funds in an amount not to exceed $35,000 from reserves to fund the additional work covered by the proposed contract amendment.

Background/Discussion

At the September 6, 2018, Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October 2018 meeting to consider issuing a Request for Proposal (RFP) to conduct a market study to analyze CalOptima's provider network strategy, and to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. To allow for more discussion and public comments, members of the MAC, OneCare Connect (OCC) MAC and PAC held a special joint meeting on October 11, 2018. The joint committee recommended that the Board not issue an RFP for consulting services to analyze the provider network strategy.

At the November 1, 2018, meeting, the Board received the recommendations from the joint MAC, OCC MAC and PAC. The Board authorized issuing an RFP for consulting services to assist in analyzing the CalOptima provider network strategy and approve the related scope of work.

At the February 7, 2019 meeting, the Board authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with PHCG for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system. The Board authorized expenditure of unbudgeted funds in an amount not to exceed $300,000 from reserves to fund the agreement and directed staff to return to the Board if additional funding is recommended to complete the engagement.

On May 7, 2019, Contract No. 19-10240 was executed between CalOptima and PHCG to complete the work in accordance with the approved scope of work.

Back to Agenda

Scheduled Stakeholder Meetings included in Scope of Work approved by Board (November 1, 2018):

Kick Off Meeting with CalOptima Staff: June 7, 2019
Gather data, Research, Review and Analysis: May 2019 – October 2019
Present at Board Meeting (National models): August 1, 2019
Present at Board Meeting (Payments Models): September 5, 2019
PAC Meeting: September 12, 2019
Present Final findings to the Board (originally scheduled for November 2019): February 2020
Final meeting discussion with CalOptima Staff

While completing the course of the contracted work, it was identified that the analysis should include more input from health networks, hospitals, providers, and advisory committees to gain a more thorough understanding of CalOptima's network delivery system. As such staff is requesting approval of additional funding to allow for additional meetings with providers and presentations at CalOptima Board and advisory committee meetings.

Proposed Additional Meetings:
Meetings with interested Health Networks and Hospitals: November 2019
Present draft findings to the Board: December 5, 2019
Present draft findings to PAC: December 12, 2019

Fiscal Impact
The estimated additional cost of the contract amendment with PHCG is $35,000 and is an unbudgeted item. Management requests an amount not to exceed $35,000 from reserves to fund the recommended action.

Rationale for Recommendation
In response to the Board approval, Staff contracted with PHCG to conduct services pursuant to the approved Scope of Work and has returned to the Board with their recommendation to authorize additional funding to complete the engagement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated October 4, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services
2. Board Action dated November 1, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work
3. Board Action dated February 7, 2019, Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

Back to Agenda

4. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader *10/30/2019*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

~~1. Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system;~~

~~2. Approve the related attached Scope of Work (SOW); and~~

Continued to 11/1/2018 meeting

3. Authorize the expansion of existing actuarial service engagement with Milliman, Inc. to include the exploration of risk adjustment methodologies that will allow for appropriate comparisons of financial and utilization metrics across different health network types and authorize expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves for this purpose.

Background

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Discussion

In response to the Board's directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff has prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s).

Milliman, Inc. currently provides CalOptima with actuarial services related to the Medicare bid development, capitation rebasing, and Chronic Illness and Disability Payment System (CDPS) risk scoring used to adjust health network capitation. These services are highly complex and require significant experience with CalOptima's data and business practices. Additional actuarial services as identified as the responsibilities of the "Existing Consultant" in the attachment are similar to services currently being performed and would be expedited by using Milliman, Inc.

Consistent with the Board's direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018,

Back to Agenda

meetings. MAC and PAC members have scheduled a special joint meeting on October 11, 2018, for further discussion on these topics.

Pursuant to CalOptima Policy GA.5002: Purchasing, Staff plans to generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings will provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management anticipates returning to the Board to request authority to contract with the recommended consulting services vendor as soon as the Board's December 6, 2018, meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Should the Board adopt the recommended action to expand CalOptima's existing actuarial service engagement with Milliman, Inc. to include additional risk adjustment activities, it is an unbudgeted item. Management requests an amount not to exceed $35,000 from reserves to fund the recommended action.

Rationale for Recommendation

In response to the Board directive, Staff recommends the proposed steps, including conducting an RFP for consulting services and expanding the scope of the existing contract with Milliman, Inc. to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Following completion of the RFP process, Staff will return to the Board with further recommendations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities
2. Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

Back to Agenda

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans to include Delegated – Direct model mix, payment models (i.e., capitation, FFS,			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Back to Agenda

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
other) and other obtainable comparative metrics				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.

Back to Agenda

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Milliman	1301 Fifth Avenue, Suite 3800	Seattle	WA	98101-2646

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system; and
2. Approve the related attached Scope of Work (SOW).

Background/Discussion

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. Both the MAC and PAC recommended holding a special joint meeting on October 11, 2018, with members of the MAC, OneCare Connect (OCC) MAC and PAC to allow for more discussion and public comments from providers and community stakeholders on this topic.

At the October 4, 2018 meeting, the Board authorized expansion of the existing actuarial service engagement with Milliman, Inc. to include additional actuarial work and the expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves. The additional actuarial activities are identified as the responsibilities of the "Existing Consultant" in Attachment 1.

On October 11, 2018, members of the MAC, OCC MAC and PAC held a special joint meeting. After further discussion and public comments from stakeholders, the committees did not support the issuance of an RFP for consulting services to analyze the provider network strategy. The main reasons given were:

- No major issues or concerns with the current delivery system – CalOptima and its existing delivery system was recently recognized as the top rated public Medi-Cal plan for the fifth consecutive year;
- Study lacks a clear purpose;
- May not be the best time to conduct a study; concerns about limited resources with new program implementation forthcoming; and

Back to Agenda

- CalOptima already undergoes many audits and has quality matrices in place; no additional value to expending limited resources on retaining an outside consultant.

These concerns are addressed in greater detail in a separately agendized item under Advisory Committee Updates.

In response to the Board's prior directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s). As indicated, the Board took action at its October 4, 2018 meeting to authorize expanding the scope of the existing Milliman contract.

Consistent with the Board's prior direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018 meetings. MAC and PAC members held a special joint meeting on October 11, 2018, for further discussion on these topics.

Should the Board elect to move forward with this initiative, pursuant to CalOptima Policy GA.5002: Purchasing, Staff would generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings would provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management would return to the Board to request authority to contract with the recommended consulting services vendor at a future Board meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Rationale for Recommendation

In response to the Board directive, Staff has undertaken a vetting process on conducting an RFP for consulting services to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Should the Board authorize moving forward with this initiative, following completion of an RFP process, Staff will return to the Board with further recommendations.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

/s/ Michael Schrader *10/24/2018*
Authorized Signature **Date**

Back to Agenda

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans (particularly COHS and Local Initiative plans) to include Delegated – Direct			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
model mix, payment models (i.e., capitation, FFS, other) and other obtainable comparative metrics. Include a clear statement and analysis of recommended future directions, given the progression of ideas, pilots, and other successful models of integrated, managed care delivery systems throughout the country.				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding, including examples of progressive network models and/or payments systems employed in the country that CalOptima may want to consider in the design of its network delivery system.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.
12. Consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system	√		√	Consider information included in the CalOptima Member Health Needs Assessment as it may impact the network delivery system.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with ~~Health Management Associates (HMA)~~ Pacific Health Consulting Group for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system pursuant to the attached Scope of Work (SOW); and
2. Authorize expenditure of unbudgeted funds in an amount not to exceed ~~$250,000~~ $300,000 from reserves to fund the agreement. Staff will return to the Board if additional funding is recommended to complete the engagement.

Rev. 2/7/2019

Background

At the September 6, 2018, Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing a Request for Proposal (RFP) to conduct a market study to analyze CalOptima's provider network strategy, and to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. To allow for more discussion and public comments, members of the MAC, OneCare Connect (OCC) MAC and PAC held a special joint meeting on October 11, 2018. The joint committee recommended that the Board not issue an RFP for consulting services to analyze the provider network strategy.

At the November 1, 2018, meeting, the Board received the recommendations from the joint MAC, OCC MAC and PAC. The Board authorized issuing an RFP for consulting services to assist in analyzing the CalOptima provider network strategy and approve the related scope of work.

Discussion

Following CalOptima's standard RFP process in accordance with CalOptima Policy GA.5002: Purchasing, Staff issued an RFP and received three (3) responses from:

- Health Management Associates (HMA);
- Pacific Health Consulting Group; and
- Mazars USA LLP.

Back to Agenda

Staff held interviews between January 16, 2019, and January 24, 2019. The responses were reviewed by an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer (CFO), and Procurement Manager.

Vendor	Final Weighted Score
HMA	23.85
Pacific Health Consulting Group	22.96
Mazars USA LLP	16.67

Based on the final weighted scores, Management recommends contracting with HMA for consulting services to complete items designated as the responsibilities of the "New Consultant" in Attachment 1.

Founded in 1985, HMA is a consulting firm with significant and relevant expertise across all domains of publicly funded health care, including delivery system restructuring and procurement, strategic planning, behavioral health, long-term services and support, and managed care policy and operations. They are widely regarded as a leader in providing strategic, technical, analytical and implementation services with a special concentration on those who address the needs of the medically indigent and underserved.

In the event CalOptima cannot reach agreeable contract terms with HMA within thirty (30) days of CalOptima providing a response to any proposed contract changes, staff recommends the Board authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day period. If neither of these contracting efforts are successful within the respective thirty (30) day periods, staff will return to the Board with further updates and recommendations.

Upon completion of the contracted work, the findings will inform the Board on the current state of CalOptima's healthcare delivery system and provide recommendation on setting a future direction.

Fiscal Impact

The estimated cost of the contract with HMA is $250,000 and is an unbudgeted item. Management requests an amount not to exceed $250,000 from reserves to fund the recommended action.

Rationale for Recommendation

In response to the Board directive, Staff conducted an RFP for consulting services and has returned to the Board with their recommendation to contract with HMA to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

Back to Agenda

Attachment 1: Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans (particularly COHS and Local Initiative plans) to include Delegated – Direct			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Back to Agenda

Attachment 1: Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
model mix, payment models (i.e., capitation, FFS, other) and other obtainable comparative metrics. Include a clear statement and analysis of recommended future directions, given the progression of ideas, pilots, and other successful models of integrated, managed care delivery systems throughout the country.				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding, including examples of progressive network models and/or payments systems employed in the country that CalOptima may want to consider in the design of its network delivery system.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.
12. Consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system	√		√	Consider information included in the CalOptima Member Health Needs Assessment as it may impact the network delivery system.

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates	950 South Coast Drive Suite 280	Costa Mesa	CA	92626
Pacific Health Consulting Group	72 Oak Knoll Avenue	San Anselmo	CA	94960
Mazars USA LLP	1875 Century Park E. Suite 1130	Los Angeles	CA	90067

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Milliman	19200 Von Karman Ave., Suite 950	Irvine	CA	92612
Pacific Health Consulting Group	72 Oak Knoll Ave.	San Anselmo	CA	94960

Back to Agenda

This item was continued to the December 5, 2019 Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact
Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action
Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background
On April 4, 2019, the CalOptima Board of Directors committed expenditures of $100 million for Homeless Health Initiatives within a three-year period. At that time, $40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional $60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the $60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the $60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the Board's October 3, 2019 meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration.

Discussion
The Board recognizes that the approved $60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute new initiatives that are most impactful and relevant to our members experiencing homelessness. Staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Ultimately, the Board has discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Back to Agenda

Fiscal Impact
The Board approved the allocation of up to $60 million for new homeless health initiatives at the February 22, 2019, Special Board of Directors meeting. The recommended action to approve the Homeless Health Initiatives Guiding Principles has no additional fiscal impact.

Rationale for Recommendation
The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Homeless Health Initiatives Guiding Principles
2. Crosswalk: Homeless Health Initiatives Guiding Principles and Funding Categories

/s/ Michael Schrader *10/30/2019*
Authorized Signature **Date**

Back to Agenda

CalOptima
A Public Agency
Better. Together.

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
September 20, 2019

Organizations across Orange County are actively responding to the local homelessness crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit $100 million in a restricted homeless health reserve. At that time, $40 million was directed to a range of specific initiatives, and $60 million was for unidentified new initiatives:

Projects *(as of April 4, 2019)*	**Allocated**	**Unallocated**	**Funding Category**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup Costs	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million		IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million		
New Initiatives		$60 million	
Total Reserve: $100 million	**$40 million**	**$60 million**	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining $60 million in funding allocations for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers –$10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. To move forward effectively, the Board and staff have developed guiding principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Ultimately, the Board has discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

Back to Agenda

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these guiding principles starts from this place of inclusiveness.

- *CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.*

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. IGT 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 (and subsequent IGT) dollars must be used according to different guidelines that restrict the spending to Medi-Cal covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. Financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the $60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's efforts to better serve members experiencing homelessness is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes, not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

- *CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.*

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure that the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

- *CalOptima shall identify measures of success and develop incentives to boost accountability in all new homeless health initiative.*

Back to Agenda

CalOptima
A Public Agency
Better. Together.

CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES AND FUNDING CATEGORIES

October 17, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	**Authorize mobile health team to respond to all homeless providers**	**Residential support services and housing navigation**	**Extend recuperative care for homeless individuals with chronic physical health issue**
Guiding Principles	**Transparent and Inclusive*** *Transparent planning that includes providers and other key stakeholders*	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: CalOptima and our health networks transparently and inclusively provide case management and care coordination under the basic Medi-Cal program. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.	Consistent: Beyond the WPC pilot to which CalOptima previously allocated funds for recuperative care, today recuperative care is not currently a Medi-Cal benefit. However, CalOptima is planning to advocate with providers and other key stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.
		*Assumes continued coordination of input from bi-weekly HN/Hospital meetings with CalOptima Board Homeless Health Ad Hoc.			
	Compliant and Sustainable *Sustained Medi-Cal funding for CalOptima from DHCS*	Consistent: Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms of ongoing state funding.	Consistent: Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in terms of ongoing state funding.	Consistent: Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a covered benefit under HHP. Consequently, there is sustainable funding within these parameters.	Inconsistent: Inconsistent today because recuperative care is not a Medi-Cal-covered service. Consequently, there is no source of sustainable funding currently.

Back to Agenda

	Strategic and Integrated *Integration with CalOptima's contracted health care delivery system*	Consistent: Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks.	Consistent: If recuperative care becomes a Medi-Cal benefit that CalOptima covers, following completion of the WPC pilot, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable *Specific deliverables and measures of success*	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: There is definition and accountability for health networks related to case management, care coordination, and HHP CB-CME housing services.	Consistent: If recuperative care becomes a Medi-Cal benefit that CalOptima covers, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

Acronyms:
CalAIM = California Advancing and Innovating Medi-Cal
CB-CME = Community-Based Care Management Entity
HHP = Health Homes Program
IHSS = In-Home Supportive Services
MSSP = Multipurpose Senior Services Program
PACE = Program of All-Inclusive Care for the Elderly
PCP = Primary Care Physician
PSH = Permanent Supportive Housing
WPC = Whole-Person Care

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts associated with AltaMed Health Services Corporation to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts with AltaMed Health Services Corporation to:

i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program; and
iii. Clarify access standards for prenatal care.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year

Back to Agenda

terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The

recommended action to renew the existing Health Network contracts through June 30, 2020 is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, and ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File

/s/ Michael Schrader — *10/30/2019*

Authorized Signature — **Date**

Back to Agenda

AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

Back to Agenda

DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Back to Agenda

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

Back to Agenda

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Back to Agenda

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

Back to Agenda

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Back to Agenda

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

Back to Agenda

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Back to Agenda

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Back to Agenda

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Back to Agenda

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

Back to Agenda

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

Back to Agenda

- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Amendments to the Cal MediConnect (OneCare Connect) Health Network Contracts, except those associated with AltaMed Health Services Corporation, to Extend them and Incorporate Other Changes and to Amend Certain Network Contracts to Address Retroactive Rate Increase Requirements for Non-Contracted Ground Emergency Medical Transport Provider Services

Contact

Michelle Laughlin, Executive Director, Network Operations (714) 246-8400
Nancy Huang, Interim Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the OneCare Connect:

1. Health Network contracts with AMVI Care Health Network, ARTA Western California, Inc., Talbert Medical Group, P.C., Family Choice Medical Group Inc., Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network Inc., Monarch HealthCare, A Medical Group Inc., Orange County Physicians IPA Medical Group Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County, Prospect Health Plan Inc., and United Care Medical Group, Inc. to:
    i. Extend the OneCare Connect Health Network contract through and including December 31, 2020;
    ii. Add any necessary language provisions required based on the Three-Way Cal MediConnect contract (Three-Way Agreement) between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements, including language reflecting changes related to the Merit-based Incentive Payments System (MIPS) program;
    iii. Clarify access standards for prenatal care; and
2. Physician Hospital Consortium capitated Hospital contract with Fountain Valley Regional Hospital and Medical Center, and OneCare Connect Full-Risk Health Network contracts with Heritage Provider Network Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to incorporate the retrospective non-contracted Ground Emergency Medical Transport (GEMT) provider rate increase requirements for the July 1, 2018 through June 30, 2019 and the July 1, 2019 through June 30, 2020 periods, and the additional compensation to these Health Networks for such services.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (CMC) OneCare Connect beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

Back to Agenda

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight counties. OneCare Connect (OCC) was launched July 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated Health Networks to manage services to the network's assigned membership.

At its September 2017 meeting, the Board authorized the execution of a new Three-Way Agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019. At its November 2018 meeting, the Board authorized CalOptima to extend the Health Network contracts for one year through December 31, 2019.
At its October 3, 2019 meeting, the Board authorized execution of the newest version of the three-way agreement, which became effective September 1, 2019. Among the key changes of the new agreement was extension of the Cal MediConnect demonstration period through, December 31, 2022, in one-year terms. In accordance with this change, staff is seeking authorization to extend the Health Network agreements for an additional year through December 31, 2020.

Discussion

Language Provisions; Agreement with CMS and DHCS

Contract amendments will be required to include provisions to address technical revisions and any other new/revised requirements from the new Three-Way Agreement that are applicable to the OneCare Connect Health Networks. To be in compliance with the most current version of the Three-Way Agreement received from DHCS, effective September 1, 2019, staff seeks authority to amend OneCare Connect Health Network contracts to ensure contracted OCC Health Networks ensure that providers are enrolled with DHCS as Medicaid providers consistent with all Medicaid enrollment requirements. Other changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Merit-based Incentive Payment Systems (MIPS)

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program memorandum and CalOptima Policies and Procedures, Health Networks implemented the CMS Quality Payment Program known as the Merit-based Incentive Payment Systems, or MIPS. This provides for incentive payments for qualifying, non-contracted providers delivering high quality patient care; subject to CMS-prescribed criteria. Payment to health networks is contingent upon annual receipt of their provider payment adjustment confirmation report, which identifies and reports all claims qualifying for MIPS payment adjustments. Health Networks are required to submit their adjustment reports on an annual basis, starting July 2020. For dates of service January 1, 2019 through December 31, 2019, payment year is 2021. Staff seeks authority to amend contracts to include language in support of the MIPS payment adjustments to the OCC Health Networks to remain in compliance with this CMS-mandated program.

Access Standards for Prenatal Care

As it relates to maternity services and access standards for prenatal care, the OneCare Connect Contract will be updated to be consistent with CalOptima's Medi-Cal Health Network contracts. The Medi-Cal Health Network contract language ensures that the most current standards or guidelines of the American

College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for prenatal services and ensure that Physician Groups have a process in place for follow-up on Member missed appointments.

Ground Emergency Medical Transport (GEMT)

Through the DHCS-established Quality Assurance Fee (QAF) program, retrospective payments to non-contracted Ground Emergency Medical Transport providers have been approved for the State Fiscal Years (SFY) 2018-2019 and 2019-2020, up to $400 per identified service. The program has been designated as a Medi-Cal benefit, requiring CalOptima to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0434 (Specialty Care Transport), and A0225 (Neonatal Emergency Transport). Reimbursement of the difference between the base Medi-Cal rate for eligible services and the increase up to $400 is applicable toward the Physician Hospital Consortia capitated Hospital and Full-Risk Health Network contracts. Payments will be contingent on receipt of the GEMT payment adjustment confirmation report required from the health networks. Reimbursement payments will be made only in cases where the new Medi-Cal rate exceeds the Out-of-Network Medicare allowable reimbursement rate. These amendments will be renewed each year that GEMT provisions are extended past SFY 2019-2020.

Summary of Recommendations

Staff seeks Board authorization to amend the Health Network agreements as needed to extend and add any necessary language provisions required by the Three-Way Agreement, and to include language supporting the provision for MIPS, ACOG and GEMT.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019, includes OneCare Connect Health Network capitation expenses of $131 million that were based on forecasted enrollment, rates and terms of the contracts consistent with the prior year (FY 2018-19). The recommended action to renew the existing Health Network contracts through June 30, 2020, is a budgeted item with no additional fiscal impact. Management plans to include revenue and expenses for the period of July 1, 2020, through December 31, 2020, as related to the contract extensions, in the CalOptima FY 2020-21 Operating Budget.

The recommended action to amend the OneCare Connect Physician Hospital Consortium capitated hospital contract and OneCare Connect Full-Risk Health Network contracts to incorporate the retrospective non-contracted GEMT provider rate increase requirements for SFY 2018-19 is budget neutral. Funding for non-contracted GEMT provider payments for OneCare Connect was not included in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. To date, staff has not received the most updated rates from DHCS. However, revenue from the State is anticipated to be sufficient to cover the estimated costs.

Back to Agenda

Rationale for Recommendation

The recommendations made above will ensure that the contractual relationship with the Health Networks serving CalOptima's OCC members is maintained, allows flexibility to modify OCC Health Network contracts as needed based on CalOptima's Three-Way Agreement with DHCS and CMS, support CalOptima's payment obligations under the MIPS program, ensure access standards for prenatal care are aligned with the most current ACOG standards and guidelines, and Physician Health Consortium capitated Hospital and Full-Risk Health Network contracts support GEMT payments through the end of Fiscal year 2019-2020.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated December 5, 2013; Consider Participation in the Cal MediConnect Program
3. Board Action dated September 7, 2017; Authorize and Direct Execution of a New Three-Way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program
4. Board Action dated November 1, 2018; Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts
5. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments
6. CMS Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance
7. CMS Release of 2019 MIPS Payment Adjustment Data File
8. Board Action dated September 5, 2019; Consider Actions Related to Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services
9. California State Plan Amendment 19-0020

/s/ Michael Schrader *10/30/2019*

Authorized Signature **Date**

Back to Agenda

AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
ARTA Western California, Inc.	1665 Scenic Ave Dr, Suite 100	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
Talbert Medical Group, P.C.	1665 Scenic Avenue, Suite 100	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. C. Consider Participation in the Cal MediConnect Program

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400
Patti McFarland, Chief Financial Officer, (714) 246-8400

Recommended Actions
Consider the following required actions to participate in the Cal MediConnect Program:
1. Authorize and Direct the Chairman of the Board of Directors to Execute the Three-Way Agreement between the California DHCS, CMS and CalOptima for Cal MediConnect, subject to the interim final rates that will not harm the financial viability of CalOptima and reasonable and expected requirements related to operations and reporting;
2. Authorize and Direct the Chairman of the Board of Directors to Execute the California Department of Social Services' (CDSS) Contract for In-Home Supportive Services (IHSS);
3. Approve Revisions Related to Cal MediConnect to CalOptima's Fiscal Year (FY) 2013-14 Budget; and
4. Authorize the CEO to develop and/or update policies necessary to meet Cal MediConnect participation requirements and implement the program's benefit set.

Background
In June 2012, Senate Bill 1008 (2012) and SB 1036 (2012) authorized the Coordinated Care Initiative (CCI). The CCI is composed of two (2) key components that will work in tandem to improve care coordination and integration.

1. Cal MediConnect: No sooner than April 1, 2014, the state will begin a three (3) year federal-state demonstration program in eight (8) counties. Individuals with Medicare and Medi-Cal (i.e., dual eligible beneficiaries) will receive coordinated medical, behavioral health, institutional long-term care, and home and community based services through a single Medi-Cal managed care plan. The participating counties are: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino.

2. Managed Medi-Cal Long-Term Supports and Services (MLTSS): No sooner than April 1, 2014, all Medi-Cal beneficiaries, including dual eligible beneficiaries, will receive long-term services and supports and Medi-Cal wrap-around benefits through a Medi-Cal managed care plan. MLTSS includes institutional long-term care, Community Based Adult Services, Multipurpose Senior Services Program, and IHSS.

   As a County Organized Health System (COHS), CalOptima already serves dual eligible beneficiaries, and provides Medi-Cal wrap-around services to members. In addition, pursuant to SB 94 (2013), DHCS separated the MLTSS component from the Cal MediConnect program. Medi-Cal managed care plans will provide MLTSS as a Medi-Cal benefit to all enrollees even if Cal Medi-Connect does not move forward.

Back to Agenda

DHCS initially proposed to implement Cal MediConnect no sooner than January 1, 2014. However, DHCS revised the timeline several times to accommodate ongoing negotiations with CMS and to resolve other implementation issues. On August 13, 2013, DHCS formally announced that Cal MediConnect will begin no sooner than April 1, 2014. Initial enrollment will occur on a passive enrollment basis for a twelve (12) month period, based on the eligible beneficiary's birthday month.

CalOptima's FY 2013-14 Operating Budget projected an increased enrollment of 27,000 members from the Cal MediConnect program through June 30, 2014. Staff will make a downward adjustment to the membership projection due to the delayed implementation date, and anticipates approximately 3,700 members will be passively enrolled each month. Staff will implement strategies to minimize the opt-out rate of the Cal MediConnect program.

The Demonstration Years for the Cal MediConnect program are as follows:

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

On May 3, 2012, your Board approved a pre-implementation budget for the CCI of $373,994 to proceed with the application process to participate in the program. The funds were used to support travel and training, consultant fees, limited term staffing, and outreach and engagement. The budget was for the period of May 3, 2012, through August 31, 2012.

On January 3, 2013, your Board approved additional funding to continue pre-implementation planning for the CCI of $615,000 for a total of $988,994. The funds were used to support professional fees and staffing. To date, approximately ninety-five percent (95%) of the pre-implementation funds have been spent. Based on Board approval, staff has completed all state and federal applications and additional requests, including but not limited to:

Key Deliverables	Date
DHCS Request for Solutions	February 23, 2012
CMS Capitated Financial Alignment Demonstration application	May 23, 2012
Proposed Model of Care	June 29, 2012
Proposed Medication Management Therapy Program	May 6, 2013
Proposed Part D Formulary	May 31, 2013
Proposed Plan Benefit Package	June 3, 2013
Revised Health Service Delivery Tables for Network Validation	June 26, 2013

Key steps and milestones for the Cal MediConnect program are as follows:

Key Steps and Milestones	Date
Finalize Memorandum of Understanding (MOU) (CMS and DHCS)	Executed March 27, 2013

Back to Agenda

Key Steps and Milestones	Date
Develop final capitation rates	Ongoing since April 23, 2013
Conduct joint readiness assessments (CMS and DHCS)	Initiated March 2013 and ongoing through December 2013 - Desk Review: April 19, 2013 - On-site visit: July 25-26, 2013 - Remote Systems Testing: October 21, 2013 - Network Validation: October 28, 2013 - Pre-Enrollment Validation: November 20, 2013 - Final Readiness report to be issued mid-December 2013
Execute MOUs with relevant county agencies	Completed in July and August 2013
Sign Three-Way contract	December 13, 2013 (electronic signature) December 16, 2013 (hard copy signature)
Sign CDSS contract for IHSS services	Mid-December 2013 (anticipated)
Finalize Plan Benefit Package in CMS system	Mid-December 2013
Implement Cal MediConnect	No sooner than April 1, 2014

On June 6, 2013, your Board approved CalOptima's FY 2013-14 Operating Budget. Staff clarified that the operating budget did not include infrastructure and implementation funding for the Duals Demonstration (i.e., the Cal MediConnect program), and that Staff would present the budget as a separate Board action.

Discussion

Both DHCS and CMS are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of Cal MediConnect. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted, as noted above, from the prior dates shared with the Board in previous meetings. Staff participated in the on-site readiness review July 25-26, 2013.

The next key step is for CalOptima to sign the Three-Way Agreement with CMS and DHCS. Recently, DHCS notified participating plans that the final date by which CMS will require execution of the Agreement is December 10, 2013. Plans, including CalOptima, received the "final" Three-Way Agreement on November 6, 2013 and were advised that they would not be able to negotiate changes to the Agreement. Although the document contains a number of terms that are currently in other program agreements, this was the first time that plans received the document which contains new Cal MediConnect program requirements, Plans had approximately one week to review the document and submit a list of "significant concerns" to the Agreement. DHCS held a conference call with plans on November 20, 2013 to discuss the comments plans submitted. On the call, the DHCS provided clarification on certain terms, but essentially reiterated that the "final" version was, in fact, final. CMS and DHCS issued interim final rates in late October for plans' thirty (30) day review. Additionally, DHCS has indicated that rates may be subject to additional minor revisions prior to the final execution of the Agreement.

Three-Way Cal MediConnect Agreement

The Agreement between DHCS, CMS, and CalOptima outlines the respective obligations for each party to implement the Cal MediConnect program in Orange County. The Agreement contains provisions for CMS

Back to Agenda

and DHCS to evaluate CalOptima's performance as a Cal MediConnect participating plan, including adherence to federal Medicare and Medicaid laws.

Below are some areas within the Agreement that will have a significant operational and financial impact:

Requirement / Area of Concern	Impact
Benefits and funding streams	The Agreement reflects continued fragmentation of Medicare and Medi-Cal benefits, services, and funding streams will pose operational challenges. Full integration will likely not occur until year 2 of the demonstration.
Care coordination	The Agreement includes extensive care coordination requirements that conflict with the existing Medicare requirements for a plan's Model of Care are included in the Agreement. Specifically, the ten (10) day timeframe to develop Individualized Care Plans (ICPs) for members after completion of the Health Risk Assessment (HRA) is insufficient.
Rate dispute process	The Agreement excludes rates from the dispute process. Requiring participating plans to waive their legal rights to dispute a rate that may be unreasonable or actuarially unsound is particularly problematic in year 2 and 3 of the demonstration.
Quality withholds	There is a lack of specific information on the quality withhold metrics, and how plans will be measured for purposes of earning back the withheld amount based on performance. The agreement lacks a process for plans to provide meaningful input on the performance metrics that will be tied to the quality withholds for each Demonstration year.
IHSS	Plans are required to assume full risk for IHSS provider payments (i.e., wages and benefits, such as health insurance). The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December. CalOptima Board of Directors would likely have to make a "go / no-go" decision on the 3-way contract for Cal MediConnect in December without the opportunity to review the CDSS contract.
After-hours call capacity	Plans cannot leverage current 24-hour Nurse Advice Lines to meet the after-hours call capacity requirement as the after-hours call service needs to be staffed either by a physician or an appropriate licensed professional under his or her supervision.

Back to Agenda

Requirement / Area of Concern	Impact
Pending contracts and regulatory guidance	The Agreement incorporates requirements to comply with unissued CMS/DHCS guidance. These references in the Agreement are broad and are not limited to indicating that the guidance will do no more than interpret current requirements under State and Federal laws.
Advisory Committee	Requires the formation of a new Advisory Committee to the Board of Directors, which must consist of not more than eleven (11) people, and no less than fifty percent (50%) of the membership of the advisory committee shall be individuals who are users of personal assistance paid for through public or private funds or recipients of IHSS services.

Other issues related to the Three-Way Agreement for Cal MediConnect include:

- Lack of specific information on IHSS;
  - Data sharing issues with the California Department of Social Services (CDSS) for IHSS; and
  - Contract terms for agreement with CDSS. The CDSS contract with the health plans is expected to be released for plan review in late November. CDSS is anticipating final contract execution in mid-December.

- Reporting requirements not yet specified (e.g., network adequacy, performance measures).

Revisions to CalOptima's FY 2013-14 Implementation, Operating, and Capital Budgets
Staff is submitting revisions to the FY 2013-14 Implementation, Operating, and Capital Budget to the BOD for approval with assumptions based on currently available information.

Proposed Budget 1/1/14 – 6/30/14			
	Implementation	**Operational**	**Total**
Average Monthly Enrollment	N/A	7,118	7,118
Revenue	$0	$43,130,331	$43,130,331
Medical Costs	$2,845,316	$38,414,385	$41,259,701
Administrative Costs	$2,879,267	$4,069,166	$6,948,433
Operating Income/(Loss)	($5,724,583)	$646,780	($5,077,803)
Medical Loss Ratio (MLR)	N/A	89.1%	95.7%
Administrative Loss Ratio (ALR)	N/A	9.4%	16.1%
Capital – Hardware/Software			$1,100,000

Enrollment Assumptions:
- Begins April 1, 2014 with an estimated 3,680 members
- Assumes a pre-enrollment opt-out rate of 20% and disenrollment rate of 5%

Back to Agenda

- CY 2014 enrollment will consist of FFS Medicare membership, since Medicare Advantage enrollees are allowed to stay with existing plan through Dec 2014

Revenue Assumptions:
- Bases Medicare rates on draft rates provided in October 2013
- Bases Medi-Cal rates on draft rates provided on November 20, 2013
- Estimates total revenue of $2,019.74 per member per month
- Medicare Part A/B and Part D rates utilizes a base rate and applies a risk adjustment factor (similar to OneCare revenue)
- Medi-Cal rate is a blended rate of four population cohorts: LTC, HCBS High, HCBS Low, and Community Well
- Adjusts rates for savings targets that escalate from 1.4% to 5.5% over the next three and a half years

Medical Cost Assumptions:
- Assumes an average provider capitation rate of 37.5% of Medicare Part A/B premium
- Uses current OneCare medical utilization and unit cost rates as a proxy
- Assumes an MLR of 85.3% on prescription drug benefits
- Assumes an MLR of 90.3% on Medi-Cal wrap-around benefits
- Excludes supplemental benefits with the exception of mental health and transportation services
- Includes program guidelines that require higher levels of Case Management and Health Services
- Estimates eighty-two (82) FTE's are scheduled over the remainder of the year

Administrative Cost Assumptions:
- Includes implementation costs of $5.7 million to prepare the organizations processes, policies, and staff for a targeted go-live date of April 1, 2014
- Program guidelines specify staffing requirements, such as Compliance and Customer Service
- Estimates sixty-three (63) FTE's are scheduled over the remainder of the year
- First twelve (12) months of the program will require higher than standard level of cost for initial items such as member and provider mailings as well as staff recruitment and training. These costs are staged in to occur approximately three (3) months prior to the member enrollment.

Capital Assumptions:
- Includes hardware and software required to support the increase in staffing and projected membership population

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
CCMS (Medical Database)	$ 222,300	20%
Facets Upgrades	204,300	19%
Backup Environment	67,240	6%
Core Infrastructure	58,020	5%
Data Warehouse	43,000	4%

Back to Agenda

Proposed Program Infrastructure by Project Type		
	Amount	**% of Total**
Misc (Network Costs)	505,140	46%
Total	$ 1,100,000	100%

The Proposed budget includes hardware, software, and professional fees.

Next Steps:
After receipt and review of the Three-Way Agreement and analysis of the interim final rates, Staff recommends the BOD to authorize the Chairman to execute the Three-Way Agreement for CalOptima to participate in Cal MediConnect.

Concurrently, Staff will continue to prepare for the implementation of Cal MediConnect and Managed MLTSS.

Approval of the proposed actions and the Board Chair's execution of the three-way agreement with CMS and DHCS will commit CalOptima to participating in the Cal MediConnect Program.

Fiscal Impact
As outlined above, the proposed revisions to the CalOptima FY 2013-14 Implementation and Operating Budget reflect a deficit of $5.1 million and a Capital Budget of $1.1 million.

Rationale for Recommendation
The DHCS proposal to implement the CCI aligns with CalOptima's long standing commitment to better integrate acute and long term care services. This integration initiative provides CalOptima an opportunity to work with community stakeholders to design a system that fully integrates the administrative and financial responsibilities for Medi-Cal and Medicare covered services and achieve its acute and long term care integration goals.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/27/2013*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute the new three-way Agreement (Agreement), which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the Agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the Agreement, summarized in the attached appendix for amendment A-01. The amendment to the Agreement incorporated necessary provisions by the July 1, 2015 effective date for voluntary enrollment into OneCare Connect.

On July 26, 2017, CMS and DHCS released a draft version of a new Agreement for a one-week comment period. Upon its release, CMS noted that while there would not be negotiations on the Agreement, MMPs could provide written concerns to CMS and DHCS. CalOptima staff reviewed and submitted comments accordingly. CMS and DHCS will be updating the Agreement in two phases prior to the end of 2017. This first phase for this new Agreement will replaces the prior agreement currently in place in whole, is comprised of:

1. Revisions required by the Final Rule.
2. Technical revisions to ensure consistency with financial alignment demonstrations in other states.
3. An extension to the Agreement through December 31, 2019.

The second phase of revisions to the Agreement will include additional revisions, specifically those changes derived from the Governor's Fiscal Year (FY) 2017-18 State budget, including the removal of the In-Home Supportive Services (IHSS) as a benefit covered by MMPs.

As highlighted in the June 1, 2017 Board action for the amendment(s) to CalOptima's Primary Agreement with DHCS for the Medi-Cal program, implementation of the Final Rule will be a significant, multi-year process, and CalOptima staff is in the process of reviewing these requirements and anticipates subsequent

Back to Agenda

policy and procedure (P&P) changes to align with requirements in this new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action.

Discussion

On July 26, 2017, DHCS provided MMPs, including CalOptima, with a copy of the redline version of the new Agreement for Cal MediConnect. CMS and DHCS anticipated finalizing the Agreement following a one-week comment period and issuing it to MMPs for execution by August 28, 2017. Given CalOptima staff did not have sufficient time to present this new Agreement to the Board on August 3, 2017, staff shared with CMS and DHCS that CalOptima would not be able to provide signature by the requested date, but would present it to the Board in September and execute shortly thereafter. At the time of writing this Board action, the final version of the Agreement was not yet available. If the final version of the Agreement is not consistent with staff's understanding as presented in this document or if it includes significant unexpected changes, staff will return to the Board for further consideration.

In addition to an extension of the Agreement to December 31, 2019 and technical revisions to ensure consistency with financial alignment demonstrations in other states, below is a high-level summary of key changes contained within the new version of the Agreement:

Requirement	
New Definitions	New definitions were added and certain existing definitions were revised to align with new requirement from the Final Rule, specifically as they pertain to Advance Directives, Grievance and Appeals, Rural Health Clinics (RHC), and External Quality Review. Additionally, the definition for the use of County Organized Health System (COHS) was revised to include the following update: *"Unless otherwise stated, Contractors that are COHS plans, including COHS plans that have not voluntarily obtained Knox-Keene Act licensure, must comply with all the terms of the Contract, including the provisions relating to the Knox-Keene Act."*
Discretionary Involuntary Disenrollment	New procedures and requirements to allow MMPs to pursue involuntary disenrollment due to an enrollee's disruptive conduct or intentionally engaging in fraudulent behavior.
Continuity of Care	Standardizing language for consistency with DHCS Duals Plan Letter (DPL) 16-002: *Continuity of Care*, which allowed enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to twelve (12) months for *Medicare* services, similar to the timeframe currently allowed for Medi-Cal services.
Advance Directives	Maintain policies and procedures on Advance Directives and educate network providers on these policies.
Cultural Competency Training	Updated the requirement to include limited English proficiency and diverse cultural and ethnic backgrounds.

Back to Agenda

Requirement	
Access to Care Standards	Monitor providers regularly to determine compliance with timely access requirements and take corrective actions if its providers fail to comply with the timely access requirements.
Emergency Care and Post-Stabilization Care Services	Further clarifying the requirements for Emergency Care as well as explicitly adding MMPs' responsibility to cover and pay for Post-Stabilization Care Services.
Indian Health Network	Clarifying requirement to allow Indian enrollees to choose an Indian Health Care Provider as a primary care provider regardless of whether the provider is in or out of the MMP's network.
Services not Subject to Prior Approval	Have a mechanism in place to allow enrollees with Special Health Care needs to have a direct access to a specialist as appropriate for the enrollee's condition and identified needs, such as standing referral to a specialty provider.
Enrollee Advisory Committee (OneCare Connect Member Advisory Committee)	Ensure the committee meets at least quarterly; specify the composition is comprised of enrollees, family members and other caregivers who reflect the diversity of the Demonstration population; require DHCS Ombudsman reports be presented to the committee quarterly and participate in all statewide stakeholder and oversight meetings, as requested by DHCS and/or CMS.
Appeals	Provide notice of resolution as expeditiously as the enrollee's health requires, not to exceed 30 calendar days (previously 45 calendar days); include a statement that the enrollee may be liable for cost of any continued benefits if the MMP's appeal is upheld; enrollee or provider must file the oral or written appeal within 60 calendar days (previously 90 calendar days) after the date of the Integrated Notice of Action. For Expedited Appeals: Provide notice of resolution as quickly as the enrollee's health condition requires, not exceeding 72 hours (previously 3 working days) from the receipt of the appeal.
Hospital Discharge Appeals	Comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency.
Quality Improvement (QI) Program Structure and rate/outlier adjustments in the Medicare component of the capitation rate	For MMPs in Los Angeles and Orange County only: Initiate QI activities for enrollees in Medicare Long Term Institutional (LTI) status. Medicare Part A/B rate adjustments starting in January 2017 will be made for Los Angeles and Orange County MMPs only and the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect will be considered during the Medi-Cal rate development for 2017 and subsequent years.
External Quality Review (EQR) Activities	Support EQR activities and in response to EQR findings, develop and implement performance improvement goals, objectives and activities as part of the MMP's QI Program.

Back to Agenda

Requirement	
Clinical Practice Guidelines	Adopt, disseminate and monitor its use as well as review and update the practice guidelines periodically, as appropriate; Disseminate the practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees.
Medical Loss Ratio (MLR)	Plans must calculate and report an MLR in a form consistent with CMS code of federal regulations, unless a joint MLR covering both Medicare and Medi-Cal experience is calculated and reported consistent with CMS and DHCS requirements.
Medicaid Drug Rebate	Non-Part D covered outpatient drugs shall be subject to the same rebate requirements as the State is subject to, and the State shall collect such rebates from pharmaceutical manufacturers.
Moral or Religious Objections	If MMP elects to not provide, pay for, or cover a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection and furnish information about the services it does not cover.

Based on review by CalOptima's departments primarily impacted by these provisions, does not anticipate any major challenges with meeting the new requirements.

Fiscal Impact

Funding related to the recommended action to incorporate language adopting requirements outlined in the Final Rule is included in the CalOptima Consolidated FY 2017-18 Operating Budget, approved by the Board on June 1, 2017. To the extent the amendment requires significant changes to CalOptima operations, Staff will return to the Board for further consideration.

Pursuant to the requirement, "QI Program Structure and rate/outlier adjustment in the Medicare component of the capitation rate" noted in the table above, Staff reviewed enrollment data for members with Medicare LTI status to estimate the impact of the amended provision. Enrollment data showed only a small number of members will be eligible for this adjustment. As such, Staff estimates additional revenue from the outlier adjustment will be $30,000 annually.

The amendment related to extending the term of the Agreement is budget neutral to CalOptima.

Rationale for Recommendation

CalOptima's execution of the new version of the Agreement with DHCS and CMS is necessary to ensure compliance with the requirements of the Final Rule and for the continued operation of CalOptima's Cal MediConnect program through December 31, 2019. Additionally, the CalOptima FY 2017-18 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment consistent with the approved budget.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to the Agreement with DHCS and CMS for Cal MediConnect

/s/ Michael Schrader — **Authorized Signature**

8/31/2017 — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 11

The following is a summary of amendments to the Three-Way Agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246 8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to:

1. Exercise CalOptima's option to extend these agreements through December 31, 2019, and
2. Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements.

Background/Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The CalOptima Board of Directors (Board) authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched June 1, 2015 in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in the states.

In November of 2017, the Board authorized CalOptima to extend the Health Network contracts for an additional year through December 31, 2018 along with an additional one-year extension option, exercisable at CalOptima's discretion.

Back to Agenda

Staff recommends extending the CMC health network agreements through December 31, 2019 to be in alignment with CalOptima's three-way CMC contract with DHCS and CMS. Staff is also requesting the authority to exercise and extension option and extend these contracts for one year.

In addition to extending the Health Network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health networks. These changes include, but are not limited to, updating contract definitions; provider training requirements; and the requirements for reporting Health Network changes.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $142 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts through June 30, 2019 is a budgeted item with no additional fiscal impact.

Management plans to include revenue and expenses for the period of July 1, 2019 through December 31, 2019 related to the contract extension in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

Authorized Signature — **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd Suite 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	P.O. Box 6300	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

Back to Agenda

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: April 27, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) created the Quality Payment Program to reform Medicare Part B payments by rewarding the delivery of high-quality patient care through two avenues: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs). This memorandum provides guidance to Medicare Advantage organizations (MAOs) regarding the application of the MIPS payment adjustment to their payments to non-contract MIPS eligible clinicians. The guidance in this memorandum is not intended to apply to MAOs' payments to contract clinicians.[1]

CMS will address the applicability of the APM incentive payment to MA non-contract provider payments in future guidance.

Merit-based Incentive Payment System (MIPS)

Section 101(b) of the MACRA consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into one program, called the Merit-based Incentive Payment System (MIPS).

Beginning in 2017, MIPS eligible clinicians are evaluated during a MIPS performance period across the following performance categories: Quality, Advancing Care Information,[2] Improvement Activities, and Cost.[3] Based on their performance, MIPS eligible clinicians will

[1] Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

[2] Starting in 2018, the Advancing Care Information performance category will be known as the Promoting Interoperability performance category.

[3] For 2017, the MIPS payment adjustment is based on performance across the Quality, Advancing Care

Back to Agenda

receive a positive, neutral, or negative MIPS payment adjustment during the corresponding MIPS payment year. Performance in 2017 will be used to determine the MIPS payment adjustment that applies in the 2019 MIPS payment year. The MIPS payment adjustment will be applied to the amount otherwise paid for the clinician's covered professional services (i.e., services furnished by the MIPS eligible clinician and paid under or based on the Medicare physician fee schedule (PFS)).

MIPS Payment Adjustments

The maximum positive and negative MIPS adjustments for each payment year are as follows: in 2019, +/-4 percent; in 2020, +/-5 percent; in 2021, +/-7 percent; and in 2022 and subsequent years, +/-9 percent. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure that the adjustments are budget neutral. For payment years 2019 to 2024, MIPS eligible clinicians who are determined to be exceptional performers can receive an additional positive MIPS payment adjustment.

Additional information on the MIPS payment adjustments is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html.

Application of MIPS Payment Adjustment to MA Non-Contract Provider Payments

When an MAO's coverage responsibilities include payment for services furnished to an enrollee by a non-contract provider (including a provider who is "deemed" to be contracting under a private fee-for-service (PFFS) plan), the MA plan's payment to the provider must be equal to the total dollar amount that would have been authorized for such services under Medicare Parts A and B, less any cost sharing provided for under the plan. Section 1852(a)(2) of the Social Security Act (42 U.S.C. § 1395w-22(a)(2)); 42 C.F.R. § 422.100(b)(2). In addition, section 1852(k)(1) of the Social Security Act provides that a physician or other entity (other than a "provider of services" as defined in section 1861(u)) that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA plan must accept as payment in full the amount that the physician or other entity would be paid if the beneficiary were enrolled in Medicare FFS Parts A and B only; any penalty or "other provision of law" applicable to such payment under Medicare FFS would also apply to the payment from the MA plan.

Calculating the 2019 MIPS Payment Adjustment

Under Medicare FFS, the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, are applied to the Medicare paid amount for covered professional services for which payment is made under or based on the Medicare PFS. For covered professional services, the Medicare paid amount is generally 80 percent of the PFS allowed amount.

Under Medicare FFS, MIPS payment adjustments are not applied to the portion of the PFS allowed amount that represents beneficiary cost-sharing (generally 20 percent of the PFS allowed amount for covered professional services). Therefore, the total amount paid to a MIPS eligible clinician for covered professional services is the MIPS-adjusted, Medicare paid amount

---

Information, and Improvement Activities performance categories. The Cost performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine 2019 MIPS payment adjustments.

plus beneficiary cost-sharing. When a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

MIPS payment adjustments are applied on a per-claim basis. MAOs may apply MIPS payment adjustments either at the time payment is made to a MIPS eligible non-contract clinician for covered professional services furnished during the applicable MIPS payment year or as a retroactive adjustment to paid claims. CMS recommends that MAOs that apply a retroactive adjustment to paid claims provide notice to affected non-contract clinicians as soon as possible to eliminate concern that the combined payment from the MAO and plan member will not equal the applicable MIPS-adjusted payment amount. MAOs must continue to meet the prompt payment requirements in section 1857(f)(1) of the Act and 42 C.F.R. § 422.520(a).

Effect on MA Plan Cost-Sharing

MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services. If an MA plan requires a fixed copayment for out-of-network services, cost-sharing is limited to the copayment amount. For MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted PFS allowed amount. An MAO may calculate the net payment that it owes to a non-contract MIPS eligible clinician for a covered professional service by subtracting the member's out-of-network cost-sharing amount from the total MIPS-adjusted payment amount for the service.

For example, if a non-contract MIPS eligible clinician who is entitled to receive a MIPS payment adjustment of +4 percent bills an MAO for a covered professional service with a PFS allowed amount of $100, the total MIPS-adjusted payment amount would be calculated as follows:

Medicare paid amount:	80% * $100 = $80
MIPS-adjusted Medicare paid amount:	104% * $80 = $83.20
Medicare FFS cost-sharing:	20% * $100 = $20
Total MIPS-adjusted payment amount:	$103.20

In the above example, if the MA plan uses a coinsurance method of cost-sharing for out-of-network services, and plan-allowed coinsurance is 30 percent, the plan member would be responsible for 30 percent of the total MIPS-adjusted payment amount, and the MAO would be responsible for the remaining 70 percent.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing (30% coinsurance):	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24

If the MA plan requires a $30 copayment for out-of-network services, the MAO would be responsible for the total MIPS-adjusted payment amount net of the beneficiary's $30 copayment.

Total MIPS-adjusted payment amount:	$103.20
Enrollee cost-sharing ($30 copayment):	$30
MA plan liability:	$103.20 – $30 = $73.20

MIPS Adjustment File Access

For each MIPS payment year (starting with 2019), CMS will upload to HPMS (https://hpms.cms.gov) a data file that lists each MIPS eligible clinician (identified by a unique Taxpayer Identification Number and National Provider Identifier (TIN/NPI) combination) and the applicable MIPS payment adjustment percentage, including any additional adjustments for exceptional performance. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments).

CMS will issue an HPMS announcement informing MAOs of the release of the MIPS adjustment data file. We expect that this file will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

Additional Information

If you have questions about this HPMS notice, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PLAN PAYMENT GROUP

DATE: November 8, 2018

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer Harlow /s/
Deputy Director, Medicare Plan Payment Group

SUBJECT: **Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance**

On April 27, 2018, CMS issued a memorandum that provided guidance to Medicare Advantage organizations (MAOs) regarding the application of the Merit-based Incentive Payment System (MIPS) payment adjustment to their payments to non-contract MIPS eligible clinicians.

This memorandum supplements our original guidance by providing the file layout for the MIPS payment adjustment data file. In addition, this memorandum clarifies and adds to our earlier guidance concerning the calculation of member cost-sharing and plan liability under a Medicare Advantage (MA) plan that uses a coinsurance method of cost-sharing.

MIPS Payment Adjustment Data File

Our April 27, 2018 memorandum explained that for each MIPS payment year (starting with 2019), CMS will upload to the Health Plan Management System (HPMS) (https://hpms.cms.gov) a data file that contains the information MAOs can use to determine the amount of the MIPS payment adjustment that applies to each MIPS eligible clinician's payments for Medicare Part B covered professional services. The data file will be added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). We continue to expect that the MIPS payment adjustment data file for 2019 will be made available at the end of 2018, after CMS has completed targeted reviews of MIPS payment adjustment factors.

File Layout

The MIPS payment adjustment data file will consist of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)
- MIPS Adjustment Percentage

Back to Agenda

- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see Appendix A.

Additional Guidance on Cost-Sharing

In our April 27, 2018 memorandum, we explained that when a MIPS eligible clinician furnishes services to an MA plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. MA plan enrollees are responsible for plan-allowed cost-sharing for out-of-network services.

Our April 27, 2018 memorandum noted that for MA plans that use a coinsurance method of cost-sharing, MA plan members may be required to pay the coinsurance percentage multiplied by the total MIPS-adjusted Physician Fee Schedule (PFS) allowed amount. We subsequently received several requests for clarification as to whether MA plans that use a coinsurance method of cost-sharing would be permitted to apply the MIPS adjustments by increasing or decreasing the plan's share of the payment for covered non-contract Part B professional services, while holding beneficiary cost-sharing constant. Under this alternative approach, member cost-sharing would be calculated by multiplying the coinsurance percentage by the PFS allowed amount *prior to application of the MIPS adjustment*. Plan liability would then be equal to the total MIPS-adjusted payment amount minus enrollee cost-sharing.

Appendix B to this memorandum provides examples of how member cost-sharing and plan liability would be calculated under the approach discussed in our April 27 memorandum (Approach 1) and the alternative approach outlined above (Approach 2). MAOs are permitted to calculate member cost-sharing under either approach. We note, however, that we expect bid pricing to be consistent with whichever approach a plan sponsor uses to operationalize the MIPS adjustments.

Additional Information

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix A

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

Appendix B

MIPS Positive Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	+4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $83.20
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$83.20 + $20.00 = ***$103.20***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculating member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $103.20 = $30.96
MA plan liability:	70% * $103.20 = $72.24
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$103.20 - $30.00 = $73.20

MIPS Negative Adjustment Example: 30% coinsurance

Step 1: Calculate total MIPS-adjusted payment amount under Medicare FFS	
MIPS adjustment percentage:	-4%
PFS allowed amount:	$100.00
Medicare-paid amount:	80% * $100.00 = $80.00
MIPS-adjusted Medicare-paid amount:	104% * $80.00 = $76.80
Medicare FFS cost-sharing:	20% * $100.00 = $20.00
Total MIPS-adjusted payment amount:	$76.80 + $20.00 = ***$96.80***
Step 2: Calculate member cost-sharing and plan liability	
Approach 1: Calculate member cost-sharing as a percentage of MIPS-adjusted payment amount	
Member cost-sharing:	30% * $96.80 = $29.04
MA plan liability:	70% * $96.80 = $67.76
Approach 2: Calculate member cost-sharing as a percentage of PFS allowed amount	
Member cost-sharing:	30% * $100.00 = $30.00
MA plan liability:	$96.80 - $30.00 = $66.80

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: January 8, 2019

TO: All Medicare Advantage Organizations, Cost Plans, PACE Organizations, and Demonstrations

FROM: Jennifer R. Shapiro, Acting Director, Medicare Plan Payment Group

SUBJECT: **Release of 2019 MIPS Payment Adjustment Data File**

The Centers for Medicare & Medicaid Services (CMS) has uploaded to the Health Plan Management System (HPMS) the Merit-based Incentive Payment System (MIPS) Payment Adjustment Data File for payment year 2019. Medicare Advantage organizations (MAOs) can use the information in the file to determine the amount of the MIPS payment adjustment that applies to their payments for Medicare Part B covered professional services furnished by out-of-network MIPS eligible clinicians.

For guidance on when and how the MIPS payments apply to MAOs' payments to MIPS eligible clinicians, please see the April 27, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments" and the November 8, 2018 memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance."

File Access

The 2019 MIPS Payment Adjustment Data File has been added to the "Incentive Payments" section of the HPMS Data Extract Facility (HPMS Home > Data Extract Facility > Incentive Payments). After navigating to the "Incentive Payments" section, a user may download the file by selecting "MIPS Payment Adjustment Data File" under Step One, "2019" under Step Two, and "Download" under Step Three.

Due to the sensitivity of some of the information provided in the file, only the MAO's Medicare Compliance Officer will be able to access and download it. The Compliance Officer must be a registered HPMS user in order to obtain the file.

Identifying the Applicable MIPS Adjustment Percentage

The MIPS Payment Adjustment Data File consists of four data elements:

- National Provider Identifier (NPI)
- Taxpayer Identification Number (TIN)

Back to Agenda

- MIPS adjustment percentage
- A marker ("Percentage Indicator") indicating that the MIPS Adjustment Percentage is positive ("P") or negative ("N")

For more detailed information on the file layout, see the attached Appendix.

An MAO can identify the applicable MIPS adjustment percentage for a MIPS eligible clinician by matching the clinician's billing TIN/NPI combination to a TIN/NPI combination in the MIPS Payment Adjustment Data File. If an exact match for the billing TIN/NPI combination does not appear in the data file, the MAO should determine whether the NPI appears in combination with another TIN and, if so, apply the MIPS adjustment percentage associated with that TIN/NPI combination. If the NPI appears in more than one TIN/NPI combination in the data file, the MAO should apply the MIPS adjustment percentage for the TIN/NPI combination that results in the greatest total payment amount.

Additional Information

If you encounter technical difficulties when downloading the MIPS Payment Adjustment Data File from HPMS, you may contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028.

If the "Incentive Payments" hyperlink does not appear in the HPMS Data Extract Facility, you must send a request for additional access to hpms_access@cms.hhs.gov. Please note that information in the MIPS Payment Adjustment Data File is considered sensitive and may require additional levels of approval.

For questions about the information in this memorandum, please contact Sean O'Grady at sean.ogrady@cms.hhs.gov.

Appendix

MIPS Payment Adjustment Data File Layout

File Position	Format	Data Element	Comment
1 - 10	X(10)	NPI	
11 - 19	X(9)	TIN	
20 - 24	9(3)V99	MIPS Adjustment Percentage	This field shows the MIPS adjustment percentage. Additional adjustments for exceptional performance, where applicable, are included in the adjustment percentage. The percentage includes two numbers after the decimal place. For example, "00975" indicates an adjustment percentage of 9.75%.
25	X(1)	Percentage Indicator	This field will have a value of "P" or "N". "P" indicates that the MIPS adjustment percentage is positive. "N" indicates the MIPS adjustment percentage is negative.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

Back to Agenda
Back to Agenda

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Back to Agenda
Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader **Authorized Signature**

8/28/19 **Date**

Back to Agenda
Back to Agenda

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda
Back to Agenda

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 6, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 19-0020, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 30, 2019. SPA 19-0020 continues the Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers to Medi-Cal patients from July 1, 2019 to June 30, 2020.

The effective date of this SPA is July 1, 2019. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director
Western Regional Operations Group

cc: Jacey Cooper, California Department of Health Care Services (DHCS)
Lindy Harrington, DHCS
Connie Florez, DHCS
Michelle Tamai, DHCS
Adam Neighbours, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 00 20

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ 2019 $ $4,809,054
b. FFY ~~2019~~ 2020 $ $14,427,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2019 and June 30, 2020.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Mari Cantwell

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 30, 2019

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 30, 2019

18. DATE APPROVED: September 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: Director, Center for Medicaid & CHIP Services, Regional Operations Group

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

Box 7: CMS pen and ink change to update years per state response to informal questions dated 8/21/19.

FORM CMS-179 (07/92)

Instructions on Back

Back to Agenda

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for SFY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 is $339.00. The add-on is paid on a per-claim basis.

For SFY 2019-20, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, A0433, and A0434 is $339.00, and for CPT Code A0225 is $400.72. The add-on is paid for each eligible CPT Code on a per-claim basis.

Back to Agenda

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount as listed in the table above for the applicable CPT Code is considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

This item is continued to a future meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing Memorandum of Understanding with the Santa Ana Unified School District to Provide Outreach and Education Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a Memorandum of Understanding with the Santa Ana Unified School District to provide outreach and education services to district staff, employees, parents and students; and
2. Make a finding that the proposed activities are in the public interest and in furtherance of CalOptima's statutory purpose.

Background

CalOptima's statutory purpose is to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income the meet the cost of healthcare. To meet this purpose, CalOptima strives to strengthen relationships with community partners by enhancing communications, collaboration and mutual understanding of missions, goals, programs and services. One such community partner is the Santa Ana Unified School District (SAUSD).

The City of Santa Ana has the largest CalOptima membership of any city in Orange County, with over 97,000 members, or roughly 12% of CalOptima's total membership. Over 56,000 (over 58%) of the CalOptima members who reside in Santa Ana are between eighteen years of age or younger, and the vast majority are enrolled in school in the SAUSD. The SAUSD is the seventh largest school district in California, and the largest school district in Orange County with 46,208 students enrolled in Transitional Kindergarten (TK) through 12th grade. The SAUSD includes a total of 60 schools with 36 elementary schools, 9 intermediate schools and 7 high schools. Roughly 96% of SAUDS students identify as Latino-Hispanic and 91% identify as being eligible for free and reduced-price meals. Approximately 45% of CalOptima members identify as Latino.

Discussion

While CalOptima has historically provided outreach services in partnership with SAUSD, the SAUSD is now formalizing relationships with community partners and is requiring CalOptima to enter into a Memorandum of Understanding (MOU) in order to allow CalOptima to continue providing these outreach and education activities in school environments serving our members. From 2017 through August 2019, CalOptima participated in seven SAUSD-related community events. In addition, in June 2018, SAUSD launched the opening of its Wellness Centers. These centers serve as hubs where parents, family and community members can learn about and access resources; they also provide opportunities for SAUSD and its community partners, such as CalOptima, to share knowledge, collaborate on programs and coordinate services for students, potential members and their families. To date, 57 Wellness Centers have been established and 36 Family and Community Engagement (FACE) Liaisons have been hired to serve children, families and communities in SAUSD.

Back to Agenda

With the launch of the Wellness Centers, the Community Relations department provided three trainings to FACES Liaisons. Presentations were designed to increase awareness of how to enroll in Medi-Cal, CalOptima as the entity administering Medi-Cal to Orange County residents, CalOptima Medi-Cal benefits and support services, such as interpretation and transportation services. Presentations also included information on CalOptima programs such as Population Health, Long Term Services and Supports, Behavioral Health Integration, OneCare Connect and PACE.

SAUSD has requested on-going trainings for staff and participation in future community events to ensure that staff and families are educated about programs and services and informed of initiatives impacting their health care benefits. SAUSD is now requiring CalOptima to enter an MOU to allow CalOptima to continue these outreach and engagement activities in the school environments serving our members.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community outreach and education activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services to serve our members' health care needs. By entering the MOU staff will be able to continue collaboration with SAUSA to support activities that are in the public interest and in furtherance of CalOptima's statutory purpose.

Concurrence
Gary Crockett, Chief Counsel

/s/ Michael Schrader — *10/30/2019*
Authorized Signature — **Date**

Back to Agenda

A Public Agency

CalOptima

Better. Together.

CalOptima Community Health and Resource Fair

This item was continued to a future meeting

Board of Directors Meeting

November 7, 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Background

- CalOptima has a long history of participating in community events, health and resource fairs, and other public activities
  - Educate and outreach to current and potential members, considering cultural and geographic needs
  - Increase access to health care services
  - Meet community needs
  - Develop and strengthen relationships with community partners
- Community events in FY 2019
  - Received and processed 173 requests
  - Approved and attended 126 events (73%)
  - More than $97,000 in financial participation provided

Membership in Top Five Cities

City	Members	% Total Membership
Santa Ana	133,013	18.1%
Anaheim	120,478	16.4%
Garden Grove	71,339	9.7%
Westminster	39,054	5.3%
Irvine	35,758	4.9%

Note: Based on total membership of 736,827, as of October 2019

Membership by Threshold Language

Threshold Language	% Membership
English	56%
Spanish	27%
Vietnamese	11%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Source: CalOptima Fast Facts October 2019

Membership by Ethnicity

Ethnicity (Top 8)	% Membership
Latino	45%
White	18%
Vietnamese	13%
Korean	2%
Asian or Pacific Islander	2%
Black	2%
Filipino	1%
Chinese	1%

Note: Based on total membership of 736,827, as of October 2019

Addressing Need for Greater Awareness

- Members, families and others supporting them may be unaware of:
  - Medi-Cal benefits and how to apply
  - CalOptima programs and benefits
  - Other services supporting members' access to care
    - Availability of transportation
    - Providers who speak their language
    - Translated materials and interpreter services at no cost to members

Large-Scale Community Event

- CalOptima proposes to host a health and resource fair in Santa Ana in April 2020
  - Highlight CalOptima's benefits, programs and services
    - Customer Service
    - Population Health
    - Bright Steps
    - Mental Health
    - Whole-Child Model
    - Health Homes Program
    - PACE, OneCare, OneCare Connect and Long-Term Services and Supports
  - Offer health screenings
  - Invite community-based organizations to participate
  - Include multicultural activities

Community Collaboration

- Santa Ana Unified School District
  - Space at Santa Ana Sports Complex
  - Outreach to students, families and others in the community
- Orange County Hispanic Chamber of Commerce
  - Print marketing in Los Angeles Times and OC Register
  - Television and radio marketing via ABC, Univision and Telemundo
- CalOptima outreach efforts
  - CalOptima newsletters and Community Connections
  - Collaborate with other community partners
    - Vietnamese Service Providers Network
    - MECCA Multi-Ethnic Collaborative of Community Agencies
    - County agencies
    - Health networks and providers

This item was continued to a future meeting

Recommended Actions

- Authorize the expenditure of funds to host a community health and resource fair for CalOptima members and potential members:
  a. Up to $37,000 and staff time to plan and host a community health and resource fair
- Make a finding that the proposed expenditure and event are in the public interest and in furtherance of CalOptima's statutory purpose; and
- Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute documents as necessary for the events and expenditures

CalOptima's Mission

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

Back to Agenda

This item is continued to a future meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Approval of the Expenditure of Funds to Host a Community Health and Resource Fair for CalOptima Members

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the expenditure of funds to host a community health and resource fair for CalOptima members and potential members:
    a. Up to $37,000 and staff time to plan and host a community health and resource fair;
2. Make a finding that the proposed expenditure and event are in the public interest and in furtherance of CalOptima's statutory purpose; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute documents as necessary for the event and expenditures.

Background

CalOptima was established to ensure that Medi-Cal beneficiaries in Orange County have access to medically necessary, covered health care services. Since 1995, CalOptima has strived to meet the health care needs of the members it serves in a cost-effective and compassionate manner.

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other activities in furtherance of its mission and statutory purpose. In Fiscal Year 2018-19, CalOptima staff attended over 120 community health and resource fairs throughout the county to promote health and wellness among the populations CalOptima serves. These events provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, better meet the healthcare needs of Medi-Cal beneficiaries, and develop and strengthen relationships with community partners.

As the single Medi-Cal plan serving Orange County residents, it is important for CalOptima to maintain a high level of visibility in the community and engage with CalOptima members with different cultural and linguistic backgrounds within the communities in which they reside.

When looking at demographics for CalOptima members, nearly 45% of members identify as Latino; 18% identify as White; and 13% identify as Vietnamese. The top five cities with the highest percentage of CalOptima members are Santa Ana, Anaheim, Garden Grove, Orange and Fullerton.

Discussion

Through participation in events and providing member education, staff has identified a lack of awareness in certain communities of CalOptima's role in administering the Medi-Cal program, and in the range of services available to the members we serve.

Back to Agenda

To enhance current outreach and education efforts, staff recommends that CalOptima offer a community health and resource fair to increase CalOptima's visibility and presence in the community.

Staff recommends leading a large-scale community event in April 2020 and collaborating with the Santa Ana Unified School District (SAUSD) and the Orange County Hispanic Chamber of Commerce (OCHCC). SAUSD has secured the Santa Ana Public School Sports Complex located at 1801 S. Greenville Street in Santa Ana (near Raitt Street and Edinger Avenue). The two possible dates are April 4, 2020 and April 25, 2020, and SAUSD has agreed to collaborate by providing the location at no cost to CalOptima. The venue can accommodate up to 3,000 individuals and has ample parking. The OCHCC is expected to collaborate with CalOptima by providing marketing support via the Los Angeles Times, the OC Register, ABC, Univision and Telemundo. Both SAUSD and OCHCC have committed to providing outreach to the community. CalOptima staff also plans to outreach to the various communities we serve to promote the event, including, for example, leveraging our relationships within the Vietnamese community via the Vietnamese Service Provider Network, outreaching to organizations serving all CalOptima's threshold languages via the Multi-Ethnic Collaborative of Community Agencies, and to other collaborative partners such as County agencies and CalOptima's contracted health networks and providers.

As proposed, the event concept will include 40 participating community organizations who will providing services such as, but not limited to, health screenings, vision screenings and glasses, dental services, and bike helmet distribution. As proposed, the event will have a strong cultural component, with activities for participants of all ages, as well as performances honoring the cultural diversity of the members CalOptima serves. Activities are expected to include folklorico and dragon dances, a high school food competition and Zumba dance. Through this event, CalOptima will have an opportunity to showcase our programs and initiatives, including customer service, population health, mental health, Whole-Child Model, PACE, OCC, Long Term Services and Supports, and Health Homes Program.

Management believes that CalOptima leading this large-scale community event will create a unique opportunity to engage members, providers, and other stakeholders in recognizing our shared mission of meeting the healthcare needs of the members CalOptima serves.

Fiscal Impact

Funding for the recommended action of up to $37,000, and staff time, is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to increase CalOptima's visibility and presence in the community, and to offer an opportunity that reflects CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *10/30/2019*
Authorized Signature **Date**

Back to Agenda

Member Advisory Committee (MAC)

Christine Tolbert, MAC Chair

Verbal Update

Back to Agenda

Board of Directors Meeting
November 7, 2019

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Update

---

October 10, 2019 Joint Meeting of the Member Advisory Committee (MAC) OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC)

The four Board advisory committees came together to listen and provide input on the proposed CalOptima Strategic Plan as presented by Chapman Consulting. Athena Chapman and Caroline Davis of Chapman Consulting reviewed the proposed strategic plan with the committees. There were questions and recommendations from all four committees.

The four Board advisory committees also received a presentation on the comparison between the Whole Person Care Program and the Health Homes Program in a combined presentation delivered by Melissa Tober-Beers of the Orange County Health Care Agency, Candice Gomez, Executive Director, Program Implementation and Tracy Hitzeman, Executive Director, Clinical Operations.

The MAC, OCC MAC, PAC and WCM FAC appreciate the opportunity to update the Board on their current activities.

Back to Agenda

OneCare Connect Member Advisory Committee (OCC MAC)

Patty Mouton, OCC MAC Chair

Verbal Update

Back to Agenda

Board of Directors Meeting
November 7, 2019

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Update

---

October 10, 2019 Joint Meeting of the Member Advisory Committee (MAC) OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC)

The four Board advisory committees came together to listen and provide input on the proposed CalOptima Strategic Plan as presented by Chapman Consulting. Athena Chapman and Caroline Davis of Chapman Consulting reviewed the proposed strategic plan with the committees. There were questions and recommendations from all four committees.

The four Board advisory committees also received a presentation on the comparison between the Whole Person Care Program and the Health Homes Program in a combined presentation delivered by Melissa Tober-Beers of the Orange County Health Care Agency, Candice Gomez, Executive Director, Program Implementation and Tracy Hitzeman, Executive Director, Clinical Operations.

The MAC, OCC MAC, PAC and WCM FAC appreciate the opportunity to update the Board on their current activities.

Back to Agenda

Provider Advisory Committee
(PAC)

Teri Miranti, PAC Vice Chair

Verbal Update

Back to Agenda

Board of Directors Meeting
November 7, 2019

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Update

---

October 10, 2019 Joint Meeting of the Member Advisory Committee (MAC) OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC)

The four Board advisory committees came together to listen and provide input on the proposed CalOptima Strategic Plan as presented by Chapman Consulting. Athena Chapman and Caroline Davis of Chapman Consulting reviewed the proposed strategic plan with the committees. There were questions and recommendations from all four committees.

The four Board advisory committees also received a presentation on the comparison between the Whole Person Care Program and the Health Homes Program in a combined presentation delivered by Melissa Tober-Beers of the Orange County Health Care Agency, Candice Gomez, Executive Director, Program Implementation and Tracy Hitzeman, Executive Director, Clinical Operations.

The MAC, OCC MAC, PAC and WCM FAC appreciate the opportunity to update the Board on their current activities.

Back to Agenda

CalOptima

County Housing Programs and Partnership Opportunities

Revised Presentation Presented at the November 7, 2019 Board Meeting

November 7, 2019

Julia Bidwell, Director, Housing & Community Development

County of Orange

Back to Agenda

County Housing Overview

- Affordable & Supportive Housing
- Current Housing Programs
  - Orange County Housing Authority
  - Mental Health Services Act Housing
- Housing Funding Strategy
- Orange County Housing Finance Trust

Back to Agenda

Affordable and Supportive Housing

Permanent Supportive Housing (PSH)

- Very vulnerable/service needs
- Histories of homelessness

Affordable & Subsidized Housing

- Low-income
- Prioritization can happen for sub-populations

Back to Agenda

Orange County Housing Authority (OCHA)

- Covers 31 of 34 cities in OC
  - OCHA administers the HCV programs for households who reside or work in all cities of OC except Anaheim, Santa Ana and Garden Grove
- Assists about 11,000 households
  - Who is eligible? Income-based
    - Elderly persons (62+)
    - Disabled
    - Families and individuals
    - Homeless
- Over 3,800 participating property owners

Back to Agenda

Special Housing Programs

Veteran Affairs Supportive Housing (VASH)	989 vouchers for veterans experiencing homelessness referred by VA Long Beach
Mainstream	**44 vouchers for non-elderly disabled population exiting from recuperative care and connected to Whole Person Care**
Homeless Set-Aside	Up to 60 vouchers for households experiencing homelessness referred via Coordinated Entry System and connected to non-profits with MOU in place with OCHA
Continuum of Care/S+C	Up to 550 vouchers for households experiencing chronic homelessness referred via Coordinated Entry System
Family Unification Program	267 vouchers for youth at risk of homelessness and families whose lack of adequate housing is the primary reason their children are in foster care and referred by Social Services Agency
Non-Elderly Disabled II	50 vouchers for non-elderly disabled population transitioning out of skilled nursing home and refer by Dayle McIntosh Center and other partner agencies

Back to Agenda

Mental Health Services Act (MHSA) Housing

- MHSA Permanent Supportive Housing
  - Permanent supportive housing developments (apartments) with onsite supportive services. All services are customized and comprehensive, which support housing stability and community integration

Target Population: Adults who are homeless or at risk of homelessness and have a serious mental illness

Access: HCA/Adult & Older Adult Behavioral Health/Housing and Supportive Services.

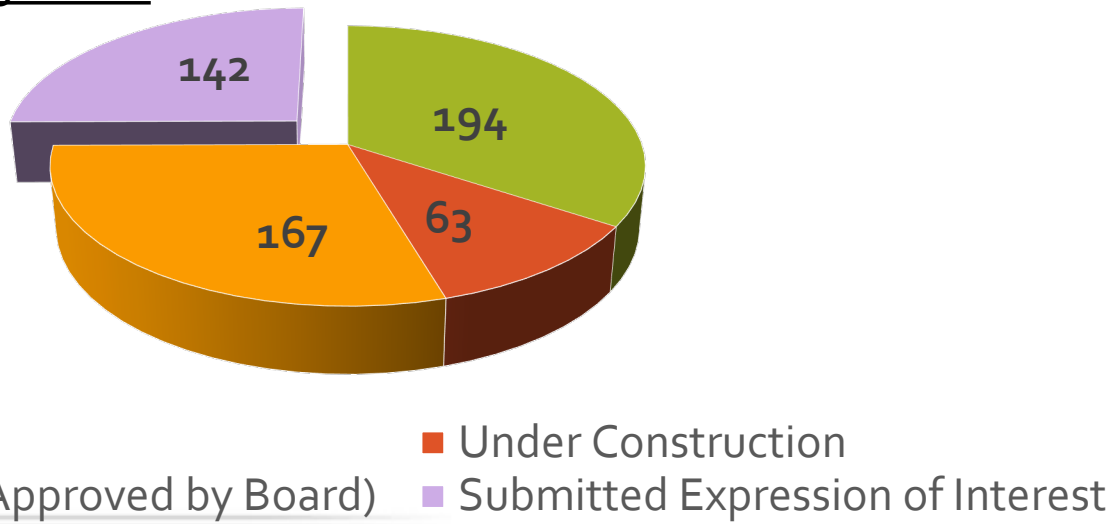
Requires application and certification of serious mental illness

Back to Agenda

MHSA Allocation and Units in Pipeline

- 2018 (Jan-March): Board of Supervisors approved total of $20 million in MHSA for housing (allocated to Special Needs Housing Program (SNHP)
- 2018 (June): Board of Supervisors recommended $70.5 million for housing in approved MHSA Permanent Supportive Housing Spending Plan

Status of MHSA Housing Units:



Back to Agenda

Housing Funding Strategy–Current Financial Model

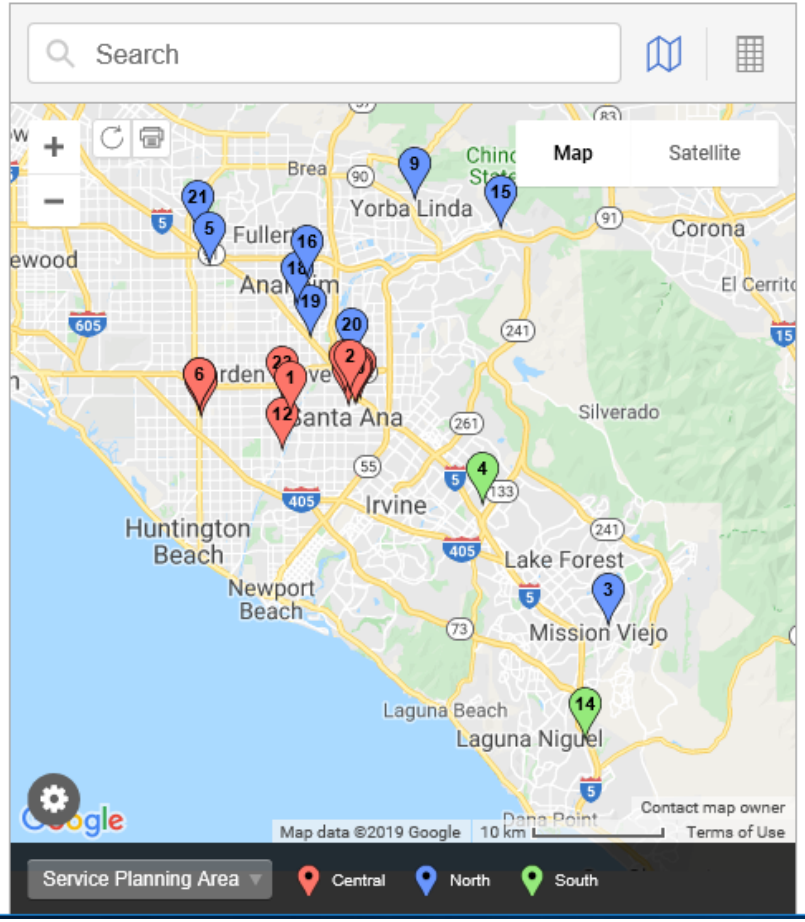
- Targeted Unit Goals = 2,700 supportive housing units in six years
- Identified sources of capital and operating funds needed to meet this goal
- Current funds needed to develop 2,700 units = $1.069B
- Current projected Capital Gap estimated at $439.6M
- Operating Gap estimated at $350M
- Important to identify significant sources of capital and operating funding

Back to Agenda

Housing Funding Strategy Status - Countywide

SERVICE PLANNING AREA	TOTAL PSH	% PSH	TOTAL UNITS	% TOTAL UNITS
Central	438	56%	760	52%
North	293	38%	544	37%
South	45	6%	155	11%
Grand Total	**776**	**100%**	**1,459**	**100%**

PROJECT STATUS	PSH-UNITS	TOTAL UNITS
Complete	24	124
In progress of funding	472	910
Under Construction	280	425
Grand Total	**776**	**1,459**



Back to Agenda

Orange County Housing Finance Trust

- The Orange County Housing Finance Trust (OCHFT) was formed in 2019 as a joint powers authority between the County of Orange and the cities throughout the county.
- OCHFT was created for the purpose of funding housing specifically assisting the homeless population and persons and families of extremely low, very low, and low income within the County of Orange.

Mission: **to strengthen the communities in Orange County by financing the development of housing for homeless and low-income individuals and families**

Vision: **to provide innovative financial solutions for the humanitarian crisis of homelessness in our local communities.**

Back to Agenda

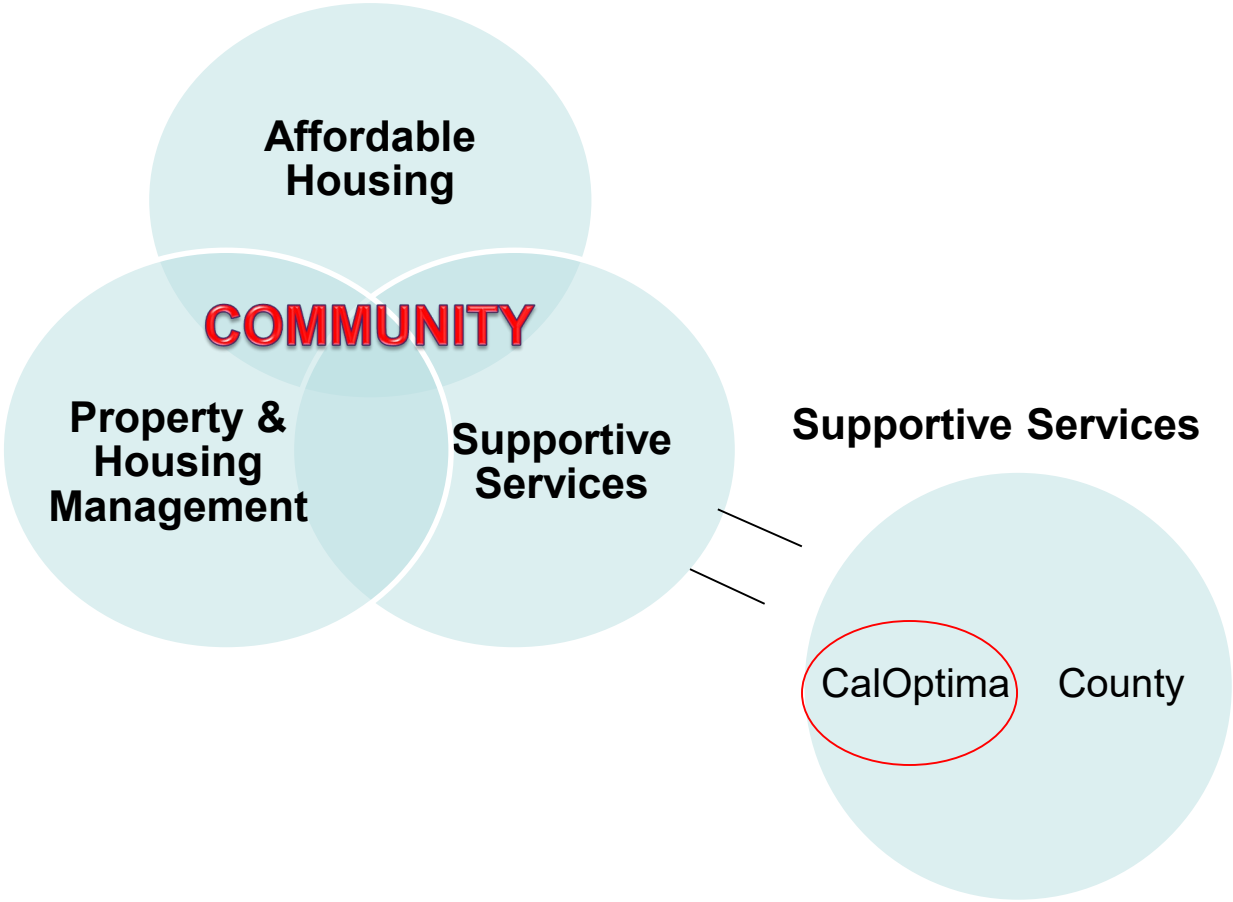
Orange County Housing Finance Trust

- Currently 22 members:

Back to Agenda

CalOptima Potential Partnership Opportunities

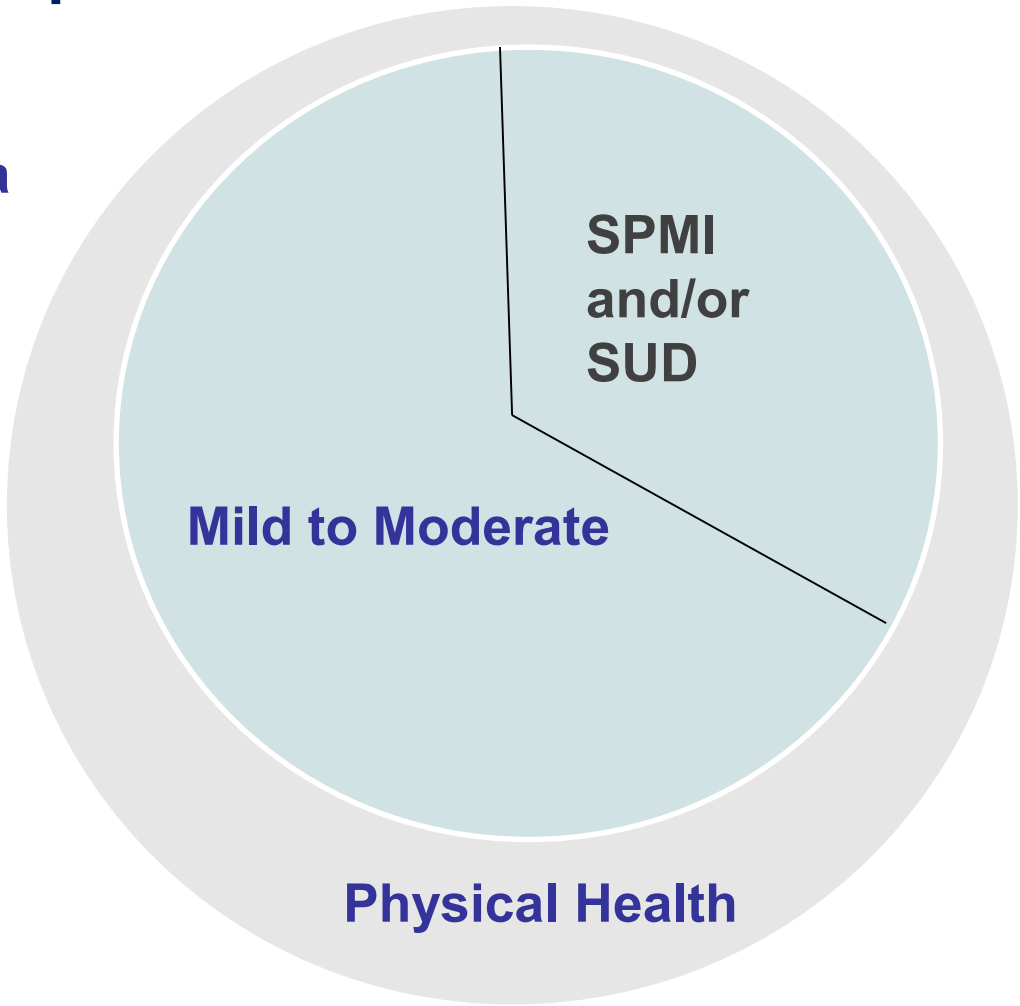
- Permanent Supportive Housing Components
- Examples:
  - Housing for a Healthy California
  - Health Homes
  - Other



Back to Agenda

Medi-Cal Population – Roles

- CalOptima
- County



Back to Agenda

Board of Directors Meeting
November 7, 2019

CalOptima Draft 2020-2022 Strategic Plan

Background
At the February 7, 2019, CalOptima Board of Directors (Board) meeting, staff presented an Information Item on the Year two (2) Progress Report of CalOptima's 2017-2019 Strategic Plan; the current Strategic Plan will expire at the end of the 2019 calendar year. The Information Item also included the planning process for CalOptima's 2020-2022 Strategic Plan. During the April 24, 2019 meeting, the Board approved a contract with Chapman Consulting to provide consulting services related to the CalOptima 2020-2022 Strategic Plan activities.

Discussion
Chapman Consulting performed work to support the development of the 2020-2022 Strategic Plan. Activities included reviewing the current and previous Strategic Plans, conducting Board of Directors and Executive staff interviews, facilitating a full-day Board of Directors planning session and recently also facilitating a joint meeting of CalOptima's Advisory Committees (Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee), as well as a meeting with Health Network representatives, and developing an Environmental Scan. A draft of the 2020-2022 Strategic Plan and the Environmental Scan are included for review.

Next Steps
Your Board's feedback to the draft, if any, will be incorporated by Chapman Consulting. Staff expects to request approval of the CalOptima 2020-2022 Strategic Plan during the December 2019 Board meeting. The priority areas will support planning and development of programs and initiatives over the course of the next few years. These will include, for example, development of the Expenditure Plan for Intergovernmental Transfer Funds expected during Fiscal Year 2020 and upcoming Quality Initiatives; staff will begin to seek stakeholder input and then return to your Board for approval of the Expenditure Plans, as appropriate.

Back to Agenda

CHAPMAN
CONSULTING

CalOptima Strategic Plan 2020-2022

DRAFT DOCUMENT FOR REVIEW

DOCUMENT PENDING GRAPHIC DESIGN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
OCTOBER 28, 2019

Back to Agenda

Message from CEO

CalOptima Staff to Provide

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

Products

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 benefits. 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 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 August 30, 2019, CalOptima has over 760,000 enrollees[i]: **(converted to pie chart in final version)**

- Medi-Cal: 746,052
- OneCare Connect (Cal MediConnect): 14,090
- OneCare: 1,545
- PACE: 345

Health Insurance Coverage in Orange County

CalOptima covers over 20% of Orange County residents.[ii]

Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%

Medicare & Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

CalOptima Enrollee Profile[iii]

Members by Age (converted to pie chart in final version):

- Age 0-18 40%
- Age 19-64 48%
- Age 65+ 12%

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 cost-effective quality health care services in a compassionate manner.

Provider Network Composition:

CalOptima has a strong provider network, which includes the contracted health networks, to serve our members:

- 1,569 primary care providers
- 6,854 specialists
- 40 acute and rehab hospitals
- 33 community health centers
- 571 pharmacies
- 99 long-term care facilities
- 5 PACE alternate 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 last three years, and this is expected to continue for the foreseeable future. The Centers for Medicare and 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 Newsom in November 2018. 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 is launching 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, combing Medicare and Medi-Cal into a single program, which is currently set to expire at the end of 2022. CalOptima will continue to engage with DHCS and CMS on how the CCI and CMC will be structured as part of the CalAIM initiative.

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 multi-faceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed $100 million to fund 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 care in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, 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 pre-paying 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:

- CalOptima's Board members, Executive Team and Advisory Committee leaders were interviewed to gather feedback about the current strategic plan as well as the issues and challenges facing the health plan over the next three years.
- Then, we held a Strategic Planning Session with the Board to review the findings from the interviews and to identify and discuss the priorities for the next strategic plan given the health care landscape in which CalOptima operates.

- Following the Strategic Planning Session, we held a joint meeting of all the Advisory Committees to solicit their input on the strategic priorities. We also convened Health Network representatives to gather their input on the next strategic plan.
- The draft 2020-2022 Strategic Plan was presented to the Board on **Month ##**, 2019 for review and discussion.
- The final 2020-2022 Strategic Plan was adopted by the Board on **Month ##,** 2019.

Strategic Priorities & Objectives

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

Innovate & 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 Provided 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

[i] Source: CalOptima Fast Facts, Available at: https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

[ii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[iii] Source: CalOptima Fast Facts, Available at:
https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

CHAPMAN
CONSULTING

CALOPTIMA 2020-2022 STRATEGIC PLAN

ENVIRONMENTAL SCAN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
SEPTEMBER 19, 2019

Back to Agenda

Introduction

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

The information from the environmental scan has been integrated with the themes and insights obtained from the interviews with CalOptima's Board of Directors, Executive Team, and Advisory Committee provides the framework for the 2020-2022 CalOptima Strategic Plan. The data in the environmental scan is as of July 2019.

CalOptima

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

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

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

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

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

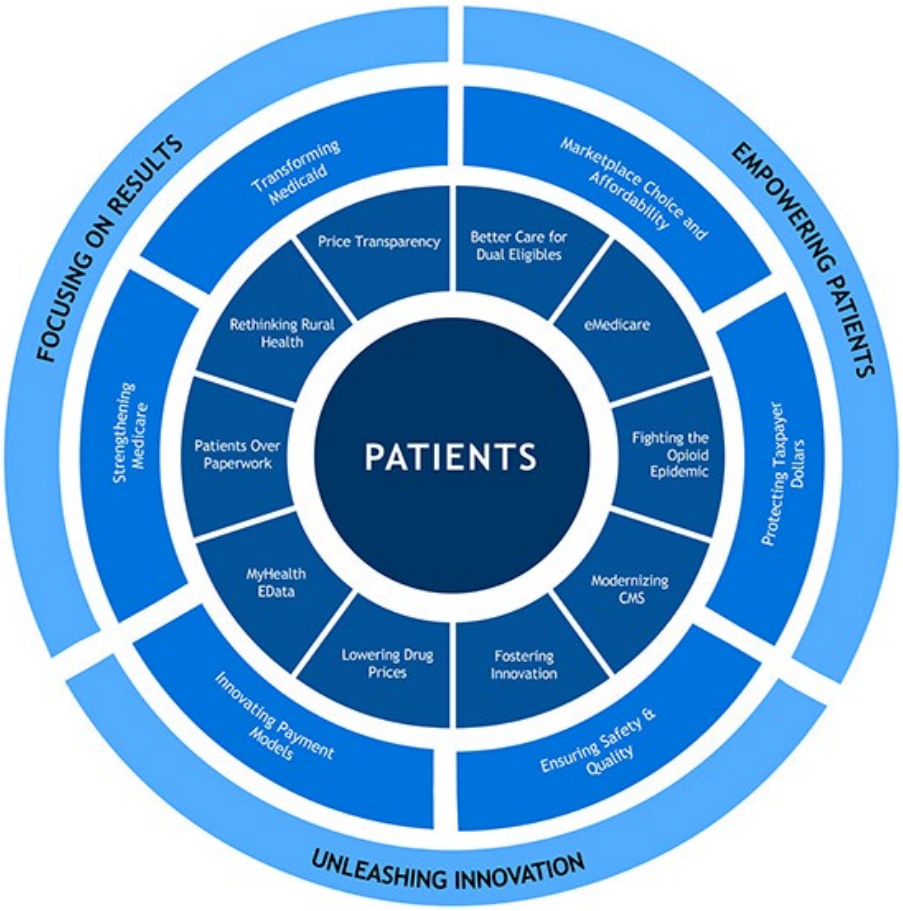
received a higher rating. CalOptima's NCQA accreditation was recently renewed at the Commendable level again.

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

Federal Landscape

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

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



Back to Agenda

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

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

State Landscape

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

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

- Enactment of a California-specific individual mandate penalty and increased subsidies for individuals and families above the ACA amounts to provide stability in the individual insurance market and increase coverage for individuals with incomes above the Medi-Cal eligibility requirements; and

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

CHHS' current guiding principles include the following:

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

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

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

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

Currently, DHCS is engaged in several initiatives and pilots that point to its direction to increase person-centered care and to integrate across programs. These include the Coordinated Care Initiative, Whole-Person Care Pilots, Health Homes, and the Whole-Child Model. CalOptima is currently involved with all these initiatives at some level and has demonstrated a commitment to being innovative and testing new programs that meet the strategic priorities of the state. As these pilots and programs are evaluated and DHCS determines how it will incorporate lessons learned into the broader Medi-Cal program, it is

inevitable there will be some expansion of the programs and some adjustments for the pieces that did not yield expected results. CalOptima is in a strong position to move forward with the state as these projects evolve and to provide input and feedback to DHCS to drive sustainable changes to the Medi-Cal program.

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

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

The current federal Section 1115 Medicaid waiver expires at the end of 2020. Currently, the entire managed care program (including the authority under which CalOptima operates) is included in the Section 1115 waiver. In addition, the waiver includes authorization for the Whole Person Care Pilots (WPCP), Public Hospital Redesign & Incentives in Medi-Cal (PRIME), the Global Payment Program, Dental Transformation Initiatives, the Drug Medi-Cal Organized Delivery System, California Children's Services (CCS) pilots, and the Coordinated Care Initiative (CCI). The federal government has changed its guidance to states regarding the calculation of "budget neutrality" (all Section 1115 waivers are required to demonstrate they do not cost the federal government more than would otherwise have been spent in the absence of the waiver), which will result in less federal funding for California under a new waiver. This shortfall will drastically reduce the amount of funding available for DHCS to invest in pilot programs and initiatives and will require the transition of many of the activities under the current waiver into sustainable models, which may involve moving those components into the managed care program. The theme of consolidation, alignment, and standardization across the Medi-Cal program is expected to be a significant part of the waiver renewal and is reflected in other activities by DHCS as outlined below. However, because many of these pilot programs, such as the WPCP, vary significantly in design and target populations by county, standardization will present unique challenges for each county, and DHCS will have to identify the components that will be included statewide.

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

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

Throughout 2019 and 2020, DHCS intends to engage stakeholders to discuss both CalAIM and the renewal of Medi-Cal's federal waivers. DHCS has indicated it will transition all existing managed care authorities into a single, consolidated 1915(b) waiver that will include the Medi-Cal Managed Care Plans, the County Mental Health Plans, the Drug-Medi-Cal Organized Delivery System Plans, and the Dental Managed Care Plans. While DHCS has yet to release a detailed CalAIM proposal, they have shared some

limited information about the stakeholder workgroups that will be formed to provide input on the development of CalAIM.[xi] Workgroup topics include: (1) Population Health Management and Annual Health Plan Open Enrollment; (2) NCQA Accreditation; (3) Enhanced Cared Management and In-Lieu-of-Services; (4) Behavioral Health; and (5) Full Integration Pilots.

DHCS Stakeholder Advisory Committee

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

DHCS Behavioral Health Stakeholder Advisory Committee

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

Prescription Drugs Executive Order

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

DHCS Managed Care Accountability Set

In early 2019, DHCS announced a major change in quality reporting requirements for the Medi-Cal health plans: health plans must report on the complete CMS Core Measures Set for both adults and children (known as the Managed Care Accountability Set in California). [xiv] This represents a significant increase in the number of measures reported and is being implemented for Measurement Year 2019. Additionally, DHCS currently requires that health plans meet a Minimum Performance Level (MPL) of 25

percent and will move to a 50 percent MPL effective for the 2019 Measurement Year. While negotiations between the health plans and DHCS have helped reduce the administrative burden and potential for sanctions in the first year of the transition, this is a heavy lift for the health plans and DHCS, and another indicator of a new Administration that is determined to make changes and maintain aggressive implementation timelines. With themes of quality and value throughout both the federal and state priorities, it is likely the pressure to demonstrate high-value care will continue to be a growing focus of DHCS.

Future of the Coordinated Care Initiative

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

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

Medi-Cal Managed Care Rates

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

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

want to provide input on these transitions to identify downstream and unintended negative consequences and to promote the timely payment of rates.

Encounter Data Reporting

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

County Landscape

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

Health Insurance Coverage in Orange County

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

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

Competitive Orange County Labor Market

According to the 2019 Orange County Community Indicators Report, the cost-of-living in Orange County is 91 percent higher than the national average, and among the highest in California. The high cost-of-living is driven largely by high housing costs. In addition, Orange County's unemployment rate (3.0 percent as of June 2019) continues its six-year trend of outperforming state and national unemployment rates (4.2 percent and 3.8 percent respectively).[xviii] The high cost-of-living coupled with a low unemployment rate are both challenges for CalOptima. As a public plan, CalOptima has difficulty competing with the private sector for staff in terms of salary. In addition, the low unemployment rate in the County means the hiring environment is very competitive.

Community Collaboration

Community Engagement

CalOptima believes in strengthening its partnerships by enhancing communications with local community organizations and supporting these important partners serving CalOptima's members' health care needs. For fiscal year (FY) 2018-2019, CalOptima participated in 126 community events to engage members and the public about CalOptima and its programs, health care and support services. Additionally, CalOptima hosts the quarterly Community Alliances Forum, which is designed to keep CalOptima connected to the health plan's community stakeholders. CalOptima also participates in more than 30 collaborative meetings throughout Orange County. Finally, CalOptima understands the importance of keeping the local community informed about health plan activities. Through their monthly community announcements and quarterly e-newsletter (known as "Community Connections"), the CalOptima provides updates on initiatives and shares information about events and training with more than 2,500 individuals and organizations.

System of Care Data Integration

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

Behavioral Health/Be Well OC

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

government. CalOptima is well positioned to leverage this local experience to demonstrate its commitment to population health management and effective delivery system transformation.

Homelessness

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

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care – As part of the Whole Person Care program, services provide post-acute care for update to 90-day stay for homeless CalOptima Members.
- Medical Respite Care – As an extension to recuperative care program, CalOptima provides additional respite care beyond 90 days of recuperative care under the Whole Person Care program.
- Clinic Field Teams – In collaboration with Federally Qualified Community Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, the pilot program provides immediate acute treatment/urgent care to homeless CalOptima Members.
- Homeless Clinic Access Program – The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County shelters.
- Hospital Discharge Process for Members Experiencing Homelessness – Support is designed to assist hospitals with the increased cost associated with discharge planning under the new State Legislative requirements.

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

Health Homes Program (HHP)

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

Whole Person Care Pilot Transition to CalOptima

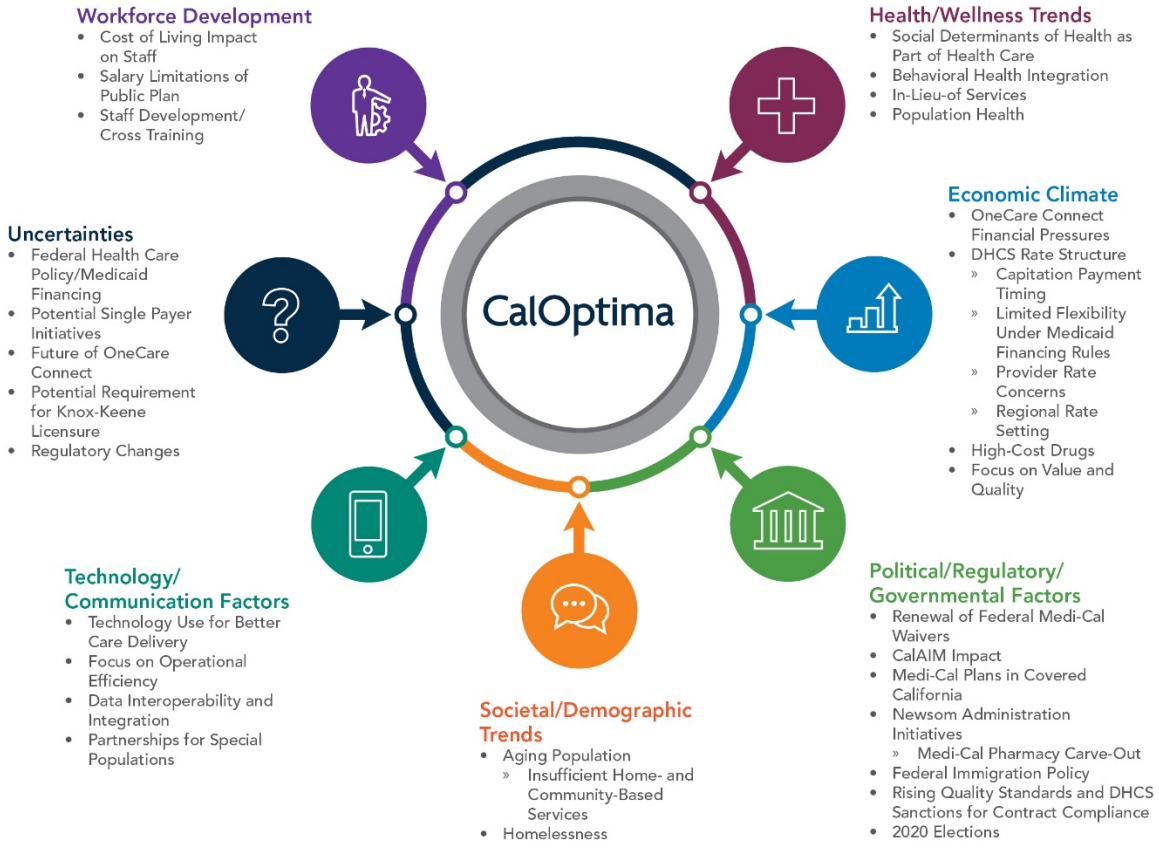
As was noted above, the WPCP are expected to transition to the Medi-Cal managed care plans when the waiver expires at the end of 2020. Orange County's Health Care Agency is the lead entity for the WPCP, and CalOptima has a limited role to provide personal care coordination services and access to covered Medi-Cal benefits. Because details are limited at this time, and it is unclear how DHCS may restructure

the individual WPCPs as they transition into managed care, CalOptima will have to be prepared to work collaboratively with the WPCP stakeholders once DHCS releases more detailed guidance and timeframes. HHP implementation will provide a foundation for this transition.

CalOptima Health Networks and Access

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

Environmental Considerations



[i] https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/NewsandPublications/2019/2019-09_FastFacts_508.ashx

[ii] Source: https://www.cms.gov/about-cms/story-page/our-16-strategic-initiatives.html

[iii] Kaiser Family Foundation Fact Sheet, "Changes to 'Public Charge' Inadmissibility Rule: Implications for Health and Health Coverage," August 2019 Update. Available at: http://files.kff.org/attachment/Fact-Sheet-Changes-to-Public-Charge-Inadmissibility-Rule-Implications-for-Health-and-Health-Coverage

[iv] https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility

[v] https://www.chhs.ca.gov/wp-content/uploads/2019/07/CHHSA-Guiding-Principles.pdf

[vi] The most recent DHCS strategic plan expired in 2018. Available at: https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[vii] https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[viii] http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/FullBudgetSummary.pdf

[ix] https://www.dhcs.ca.gov/services/Pages/Care-Coordination-Assessment-Project.aspx
[x] https://www.dhcs.ca.gov/calaim
[xi] https://www.dhcs.ca.gov/calaim
[xii] https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf
[xiii] https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcrxHome.aspx
[xiv] https://www.dhcs.ca.gov/dataandstats/Pages/Core-Set-Measures-Reporting.aspx
[xv] https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx
[xvi] http://calduals.org/
[xvii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[xviii] Orange County 2019 Community Indicators Report. Available at: https://www.ocbc.org/wp-content/uploads/2019/09/CommIndicators_Report_091219-WEB.pdf
[xix] http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf

A Public Agency

CalOptima

Better. Together.

Hospital and Community Partner Data Sharing Update

Regular Meeting of the CalOptima Board of Directors
November 7, 2019

Len Rosignoli

Chief Information Officer, CalOptima

Back to Agenda

Current State

- CalOptima has partnered with the Orange County Health Care Agency (HCA) on the Whole Person Care (WPC) Program

  - The System in use by HCA for the WPC program is known as WPC Connect

  - HCA and CalOptima - along with the following are actively using WPC Connect, with participating intended to increase:
    - 12 Hospitals
    - 10 Clinics
    - 3 Recuperative Care Centers
    - 2 Shelters
    - 4 Other Community Resources
    - 1 Health Network

WPC Connect

- Uses of WPC Connect
  - Receiving referrals from Illumination Foundation for appointment assistance, PCP changes, etc.
  - Sending referrals to Illumination Foundation for housing assistance
  - Learning when a WPC member checks in to a participating hospital's Emergency Department, or is admitted
  - Obtaining updated contact information for homeless members based on entries from shelters and recuperative care centers
  - Notification of members that have disenrolled from the program, the most common reasons being:
    - Non-compliance with the WPC program
    - Loss of Medi-Cal eligibility

Update on CalOptima's RFP

- CalOptima has planned and received budget approval to invest in one or more data sharing platform(s)/system(s).
- This will be in addition to using WPC Connect for the WPC Program. (Not a substitution).
- A Request For Proposal (RFP) was issued on 7/17/2019 to identify one or more suitable platforms/systems.
- Nine proposals were received, reviewed, and scored.
- Four vendors to date were chosen to present demonstrations. All were conducted in October.
- Follow-up questions, if any, will be handled in November with vendor selection to follow.
- Staff will update Board on vendor selection at either the December or February Board meeting.

Key RFP Evaluation Criteria/Requirements

- Near real-time notification of CalOptima member presenting at an Emergency Department.
- Near real-time notification of any admission, discharge, or transfer activity for CalOptima members within a participating hospital to the care team participants.
- Ability to monitor for multiple clinical conditions in addition to the above notifications.
- Ability to assist in identification of homeless.
- Discharge Planning with the entire care team.
- Shared Care Planning with the entire care team.
- Analytics ability for a variety of reporting including utilization, most common conditions, population management, and many others.
- Integration ability to share data as appropriate.
- Participation with Hospitals, Medical Groups, Clinics, Community Based Organizations, etc. and a plan to gain participation from more of the above.

Related Information / Projects

- In April, 2019, the CalOptima Board approved a 2% increase to Medi-Cal Classic rates for Inpatient Acute Care Hospitals based on volume of services in support of a hospital's implementation of data sharing technologies. Other potential incentives are being explored.

- CalOptima has been invited to participate with the County in its System of Care Data Integration System process. CalOptima has had two meetings to date with the County Consultant (Gartner) on this initiative.

- CalOptima is implementing its own Electronic Health Record system to further enable a more comprehensive view of each member's clinical history.

- CalOptima, HCA, and other participants meet regularly and provide feedback on requested enhancements to the WPC Connect system to continually improve the WPC program.

CalOptima Mission

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

Back to Agenda

Orange County Whole Person Care Data Sharing Update

Presented at the November 7, 2019 Board Meeting

Melissa Tober-Beers

Strategic Projects Manager / OC Health Care Agency

November 7, 2019

Back to the Agenda

WPC CONNECT
Care Coordination

- Reduce inappropriate or unnecessary ER visits/inpatient utilization
- Meet needs in real-time: social, medical and behavioral
- Increase readiness for Coordinated Entry process
- Improve/increase success in housing placement

WPC via WPC Connect Services to All Populations

- Emergency Room Notification System
- Web-Based Collaborative Care Plan Accessible by multiple organizations
- Automated referrals to Recuperative/Medical Respite Care Services
- Hospital and Clinic-Based Care Navigation/Coordination
- Managed Care Personal Services Coordinator (CalOptima)
- Supportive and Linkage Services by Shelter Bed Providers
- Housing sustainability services, including peer support
- Community Resource Referrals

Back to Agenda

OC health CARE AGENCY

DATA INTEGRATION FUNDING

Waiver Period: 1/1/2016 through 12/31/2020 (5 years)
Federal Funding: $300 million per year or $1.5 billion
County Match: $300 million per year or $1.5 billion
TOTAL Funding: $600 million per year or $3 billion

Round 1 – 1/1/2017 -12/31/20 (DHCS released application 4/2016)
Initial Application: **$23,500,000**
*Funding for WPC Hospitals and Community Clinics included additional funding for IT coordination and linkage to WPC Connect. For Hospitals, specifically real-time ER data ADT feed.

Round 2 – 7/1/2017 -12/31/20 ($60 million not allocated in Round 1)
Expansion Application: **$7,566,860**
*Funding added for data coordination with CalOptima ($449,000)

Round 3 – 7/1/2019 -12/31/20 ($40 million not able to be spent by other counties)
Proposal Range: $19 million to $25.5 million; funded at **$21.5 million**
Additional **$1.4 million** for exceeding service goals in 2018
*Funding of enhancements to WPC Connect
*Supporting the County's Data Integration Project
*Ability to fund additional hospitals to support adding WPC Connect

Total Orange County WPC Program = **$54.02 million**

Back to Agenda

OC health CARE AGENCY

WPC PARTICIPATING PROVIDERS

(AS OF 11/7/2019)

Supportive Services

Mercy House Kraemer
United Way

BHS-Outreach

OC-BHS
College
Colette's Children's Home

Clinics

Buena Park Community Clinic
Central City Community Health Center
Families Together
Hurtt Family Medical
KCS-Korean Community Health Center
Livingstone
North Orange County Regional
Serve The People
Share our Selves (SOS)
Southland (VNCOC)

Recup Care

Hurtt Family Medical (Recup)
Illumination Foundation (IF)
Mom's Retreat

Hospitals

Orange Coast Memorial
Saddleback Memorial
St. Joseph's Hospital
St. Jude Hospital
Hoag Hospital
Mission Hospital
UCI Medical Center
Anaheim Regional Medical Center
Kaiser (Anaheim & Irvine)
Chapman Global
Orange County Global
Anaheim Global
South Coast Global

Others

CalOptima
HCA-CHAT-H
HCA-MSN Referral Team
Monarch Health
St Joseph Heritage Shared Services

Back to Agenda

OC health CARE AGENCY

CalOptima
A Public Agency
Better. Together.

Health Homes Program

Board of Directors Meeting
November 7, 2019

Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

Back to Agenda

Summary

- Health Home Program Overview
  - Objectives and Goals
  - Core Team and Roles
  - Core Services
- Why Partner with Health Networks as CB-CME?
  - Delivery Model Considerations
  - Potential Member Distributions by Health Networks
  - County Survey
  - Benefits of Partnering with Health Networks
- Post-implementation Opportunities
  - Go-live Timeline
  - Future Opportunities and Considerations

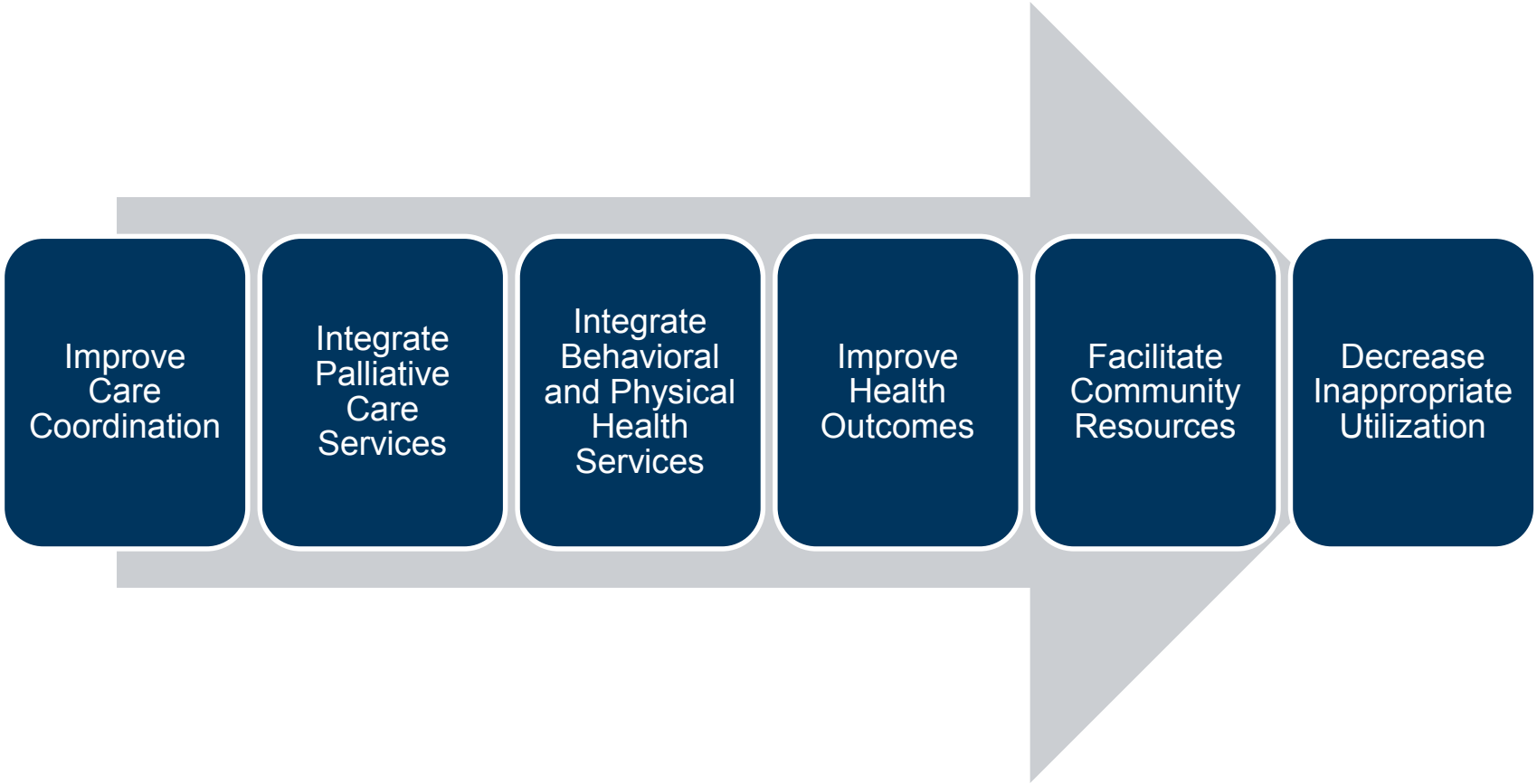
Back to Agenda

Health Homes Program (HHP) Overview

- HHP is operated by managed care plans, who choose to participate in the program
  - Community-Based Care Management Entities (CB-CMEs) engage beneficiaries and provide care management and care coordination services
  - Managed care plans and CB-CMEs also connect members to community and social service resources, including housing

- HHP is a clinical program that manages and coordinates care for the highest risk Medi-Cal members

HHP Objectives and Goals



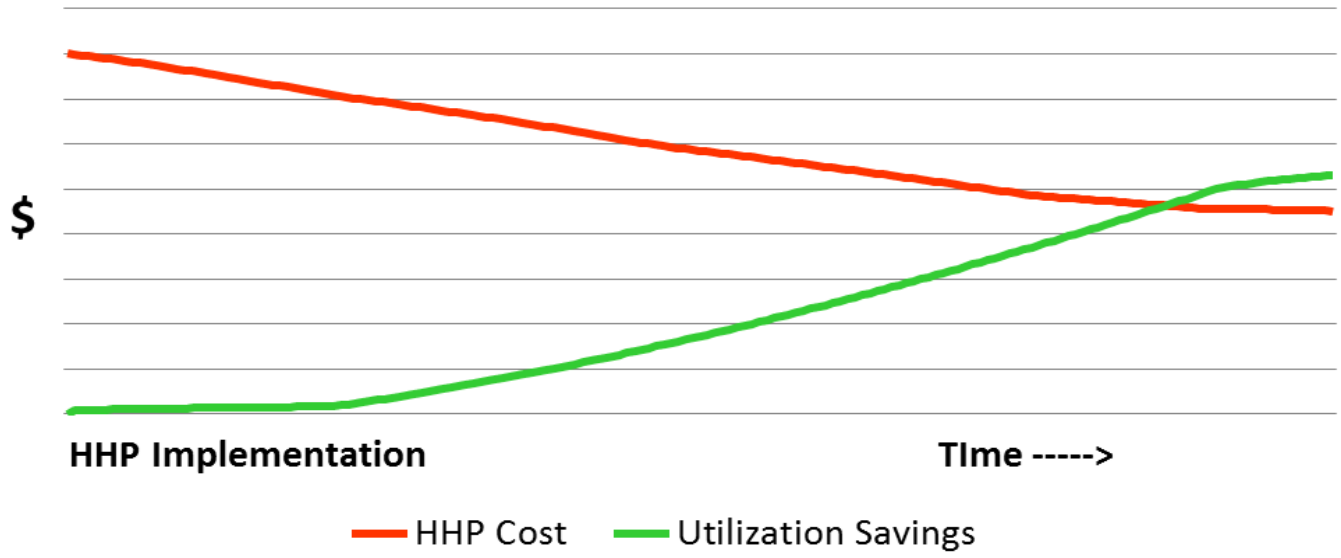
Source: DHCS All Plan CEO/CFO Meeting – December 17, 2017

Financial Objective

Main purpose of the HHP

TEL* focuses on individuals with the greatest need for Care Coordination

Program is designed to be at least cost neutral over time



Source: DHCS All Plan CEO/CFO Meeting – December 17, 2017

*Targeted Engagement List

DHCS Defined Core Team and Roles

Source: DHCS All Plan CEO/CFO Meeting – December 17, 2017

HHP Core Services

Back to Agenda

Permitted CB-CME Provider Types

- Behavioral health entity
- Community health/mental health center
- Federally qualified or Rural health center
- Indian health clinic/center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- SUD treatment provider
- Provider serving individuals experiencing homelessness

Delivery Model Considerations

- Leverage existing delivery system vs. build from scratch
- DHCS Requirements
  - Members must have the ability to participate in HHP without changing health networks or PCPs
  - CB-CME must have access to all member information (e.g., records of ED visits, hospital stays, primary and specialty care, medications, care plans, community referrals, etc.)
- CalOptima member assignment
  - For primary care, 20% are assigned to a community clinic, 80% are not assigned to a community clinic
  - Majority of CalOptima members (80%) are assigned to a health network, including CalOptima Community Network

Potential HHP Members by Health Network (August 2019)

Health Network	Member Count	DHCS Opt-In Projection (20%)	CalOptima Opt-In Projection (15%)	CalOptima Opt-In Projection (10%)
AltaMed	2,390	478	359	239
AMVI	563	113	84	56
Arta Western	3,416	683	512	342
CCN/COD	7,377	1,475	1,107	738
CHOC	1,465	293	220	147
Family Choice	1,824	365	274	182
HPN-Regal	348	70	52	35
Kaiser	1,758	352	264	176
Monarch	5,199	1,040	780	520
Noble	1,213	243	182	121
Prospect	2,041	408	306	204
Talbert	1,414	283	212	141
United Care	1,233	247	185	123
TOTAL	**30,143**	**6,029**	**4,521**	**3,014**

Note: Member count may not include members overlapping with health networks within the same month
Data Source: CalOptima Member Data

County Survey

- External vendor engaged to conduct CB-CME survey of community-based organizations and community health centers in Orange County
  - Total organization surveyed = 70
  - Total responded = 46
    - 14 were community health centers
  - Six organizations identified that could offer four or more of the six HHP services
  - Overall Observations of available providers
    - Geographic gaps in certain parts of Orange County
    - Need to build capacity in threshold languages
    - Need to build capacity to provide all six HHP service categories
    - Need to build infrastructure to support clinical information exchange, data and encounter reporting, and health action plan development and communication

Health Networks as CB-CME

- Members can participate in HHP without needing to change their health network or PCP, consistent with DHCS requirements
  - Majority of members assigned to a health network
  - Only 20% are assigned to a community clinic as the PCP

- Health networks have access to all member information (e.g., records of ED visits, hospital stays, primary and specialty care, medications, care plans, community referrals, etc.)
  - Other provider types would need to establish data sharing agreements and develop interfaces

Health Networks as CB-CME (Cont.)

- CalOptima HHP rates are a modest supplement to standard capitation, which already includes care management activities performed by health network

- Startup time reduced due to health networks' existing information systems, standard workflows and experienced staff

HHP Go-Live Timeline

- Phase I
  - Effective January 1, 2020 for members with eligible chronic physical conditions or substance use disorders
  - Health networks, including CalOptima Direct, as CB-CME
- Phase II
  - Effective July 1, 2020 for members with eligible serious mental illness conditions
  - CalOptima can approach DHCS to request flexibility to add additional CB-CMEs
  - CalOptima staff will continue to collaborate with Orange County Health Care Agency, health networks, and other stakeholders regarding Phase II of the implementation

Post-Implementation Opportunities

- CalOptima may approach DHCS to request flexibility to add additional CB-CMEs following implementation

- Considerations for adding new CB-CMEs
  - Avoid duplication of services between existing and new CB-CMEs
  - Cannot require members to change PCPs or health networks
  - Startup costs for a new CB-CME
  - Have ability to interface with various care management systems with health networks
  - Have contracts and data sharing agreements with health networks

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Financial Summary

September 2019

Board of Directors Meeting

November 7, 2019

Nancy Huang

Chief Financial Officer

Back to Agenda

FY 2019-20: Consolidated Enrollment

September 2019 MTD

Overall enrollment was 728,074 members

- Actual lower than budget 21,298 members or 2.8% mainly caused by prior year (PY) eligibility logic correction of approximately 17,000 members
  - Medi-Cal unfavorable variance to budget of 21,416 members or 2.9%
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 15,545 members
    - Medi-Cal Expansion (MCE) unfavorable variance of 4,636 members
    - Whole Child Model (WCM) unfavorable variance of 1,085 members
    - Seniors and Persons with Disabilities (SPD) unfavorable variance of 145 members
    - Long-Term Care (LTC) unfavorable variance of 5 members
  - OneCare Connect favorable variance to budget of 51 members or 0.4%
- 33,958 decrease from August
  - Medi-Cal decrease of 34,084 members
  - OneCare Connect increase of 96 members
  - OneCare increase of 19 members
  - PACE increase of 11 members

FY 2019-20: Consolidated Enrollment (cont.)

September 2019 YTD

Overall enrollment was 2,245,999 member months

- Actual lower than budget 7,290 members or 0.3%
  - Medi-Cal unfavorable variance of 7,439 members or 0.3%
    - MCE unfavorable variance of 7,134 members
    - WCM unfavorable variance of 3,096 members
    - SPD favorable variance of 2,262 members
    - TANF favorable variance of 540 members
    - LTC unfavorable variance of 11 members
  - OneCare Connect favorable variance of 6 members
  - OneCare favorable variance of 151 members or 3.4%
  - PACE unfavorable variance of 8 members or 0.8%

FY 2019-20: Consolidated Revenues

September 2019 MTD

- Actual higher than budget $100.8 million or 33.9%
  - ➢ Medi-Cal favorable to budget $100.4 million or 37.3%
    - Unfavorable volume variance of $7.9 million
    - Favorable price variance of $108.3 million
      - $104.3 million recognized for fiscal year (FY) 2018 Directed Payments (DP)
      - $3.0 million of Coordinated Care Initiative (CCI) revenue
  - ➢ OneCare Connect favorable to budget $0.2 million or 1.0%
    - Favorable volume variance of $86.2 thousand
    - Favorable price variance of $0.1 million
  - ➢ OneCare favorable to budget $0.2 million or 10.9%
    - Favorable volume variance of $72.6 thousand
    - Favorable price variance of $0.1 million
  - ➢ PACE unfavorable to budget $30.3 thousand or 1.1%
    - Favorable volume variance of $7.8 thousand
    - Unfavorable price variance of $38.1 thousand

FY 2019-20: Consolidated Revenues (cont.)

September 2019 YTD

- Actual higher than budget $106.0 million or 11.9%
  - Medi-Cal favorable to budget $103.2 million 12.8%
    - Unfavorable volume variance of $2.7 million
    - Favorable price variance of $105.9 million due to $104.3 million of DP revenue
  - OneCare Connect favorable to budget $2.2 million or 3.1%
    - Favorable volume variance of $10.1 thousand
    - Favorable price variance of $2.2 million due to favorable Medicare capitation rates

FY 2019-20: Consolidated Medical Expenses

September 2019 MTD

- Actual higher than budget $103.7 million or 37.1%
  - ➢Medi-Cal unfavorable variance of $103.9 million or 41.2%
    - Favorable volume variance of $7.4 million
    - Unfavorable price variance of $111.2 million
      - Reinsurance and Other expenses unfavorable variance of $103.4 million related to FY 2018 DP expenses recognized
      - Provider Capitation expenses unfavorable variance of $3.2 million
      - Facilities expenses unfavorable variance of $2.1 million
      - MLTSS expenses unfavorable variance of $2.0 million
    - Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in September 2019
  - ➢OneCare Connect favorable variance of $43.5 thousand or 0.2%
    - Unfavorable volume variance of $83.6 thousand
    - Favorable price variance of $0.1 million

FY 2019-20: Consolidated Medical Expenses (cont.)

September 2019 YTD

- Actual higher than budget $113.8 million or 13.4%
  - ➢ Medi-Cal unfavorable variance of $112.7 million or 14.7%
    - Favorable volume variance of $2.6 million
    - Unfavorable price variance of $115.3 million
      - Reinsurance and Other expenses unfavorable variance of $99.2 million due to DP
      - Professional Claims expenses unfavorable variance of $9.6 million
      - Facilities expenses unfavorable variance of $6.0 million
      - Provider Capitation expenses unfavorable variance of $1.9 million
      - Medical Management expenses favorable variance of $3.1 million
  - ➢ OneCare Connect unfavorable variance of $1.5 million or 2.2%
    - Unfavorable volume variance of $9.9 thousand
    - Unfavorable price variance of $1.5 million

Medical Loss Ratio (MLR)

- September 2019 MTD: Actual: 96.2% Budget: 94.0%
- September 2019 YTD: Actual: 96.3% Budget: 95.0%

FY 2019-20: Consolidated Administrative Expenses

September 2019 MTD

- Actual lower than budget $1.8 million or 13.8%
  - Salaries, wages and benefits: favorable variance of $0.8 million
  - Other categories: favorable variance of $0.9 million

September 2019 YTD

- Actual lower than budget $5.9 million or 15.2%
  - Salaries, wages and benefits: favorable variance of $3.3 million
  - Other categories: favorable variance of $2.6 million

Administrative Loss Ratio (ALR)

- September 2019 MTD: Actual: 2.7% Budget: 4.3%
- September 2019 YTD: Actual: 3.3% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% MTD and 3.7% YTD

FY 2019-20: Change in Net Assets

September 2019 MTD

- $5.6 million change in net assets
- $0.9 million unfavorable to budget
  - Higher than budgeted revenue of $100.8 million
  - Higher than budgeted medical expenses of $103.7 million
  - Lower than budgeted administrative expenses of $1.8 million
  - Higher than budgeted investment and other income of $0.2 million

September 2019 YTD

- $12.7 million change in net assets
- $3.8 million favorable to budget
  - Higher than budgeted revenue of $106.0 million
  - Higher than budgeted medical expenses of $113.8 million
  - Lower than budgeted administrative expenses of $5.9 million
  - Higher than budgeted investment and other income of $5.6 million

Enrollment Summary: September 2019

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
65,215	65,451	(236)	(0.4%)	Aged	195,935	195,959	(24)	(0.0%)
503	615	(112)	(18.2%)	BCCTP	1,630	1,845	(215)	(11.7%)
43,999	43,796	203	0.5%	Disabled	133,994	131,493	2,501	1.9%
269,741	284,825	(15,084)	(5.3%)	TANF Child*	857,654	858,645	(991)	(0.1%)
86,674	87,135	(461)	(0.5%)	TANF Adult	264,396	262,865	1,531	0.6%
3,399	3,404	(5)	(0.1%)	LTC	10,201	10,212	(11)	(0.1%)
230,582	235,218	(4,636)	(2.0%)	MCE	698,257	705,391	(7,134)	(1.0%)
11,855	12,940	(1,085)	(8.4%)	WCM**	35,724	38,820	(3,096)	(8.0%)
711,968	**733,384**	**(21,416)**	**(2.9%)**	**Medi-Cal**	**2,197,791**	**2,205,230**	**(7,439)**	**(0.3%)**
14,186	**14,135**	**51**	**0.4%**	**OneCare Connect**	**42,533**	**42,527**	**6**	**0.0%**
1,564	**1,498**	**66**	**4.4%**	**OneCare**	**4,639**	**4,488**	**151**	**3.4%**
356	**355**	**1**	**0.3%**	**PACE**	**1,036**	**1,044**	**(8)**	**(0.8%)**
728,074	**749,372**	**(21,298)**	**(2.8%)**	**CalOptima Total**	**2,245,999**	**2,253,289**	**(7,290)**	**(0.3%)**

* TANF Child actuals include approximatley 13.8 thousand prior year adjustments

** Whole Child Model (WCM) was budgeted based on initial implementation date. Enrollment for WCM was transferred from the other seven aid categories.

Financial Highlights: September 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
728,074	749,372	(21,298)	(2.8%)	Member Months	2,245,999	2,253,289	(7,290)	(0.3%)
398,264,420	297,453,331	100,811,089	33.9%	Revenues	998,746,772	892,785,343	105,961,429	11.9%
383,232,533	279,530,367	(103,702,165)	(37.1%)	Medical Expenses	962,256,443	848,487,225	(113,769,218)	(13.4%)
10,902,541	12,652,832	1,750,291	13.8%	Administrative Expenses	33,185,300	39,130,227	5,944,927	15.2%
4,129,347	**5,270,131**	**(1,140,785)**	**(21.6%)**	**Operating Margin**	**3,305,029**	**5,167,891**	**(1,862,862)**	**(36.0%)**
1,473,566	1,250,000	223,566	17.9%	Non Operating Income (Loss)	9,382,523	3,750,000	5,632,523	150.2%
5,602,913	**6,520,131**	**(917,218)**	**(14.1%)**	**Change in Net Assets**	**12,687,552**	**8,917,891**	**3,769,661**	**42.3%**
96.2%	94.0%	(2.3%)		Medical Loss Ratio	96.3%	95.0%	(1.3%)	
2.7%	4.3%	1.5%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
1.0%	1.8%	(0.7%)		Operating Margin Ratio	0.3%	0.6%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%	4.3%	0.5%		Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per DHCS instructions

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	6.2	(1.7)	Medi-Cal	4.9	9.4	(4.5)
(0.8)	(1.1)	0.3	OCC	(2.7)	(4.2)	1.5
0.3	(0.1)	0.3	OneCare	0.7	(0.4)	1.1
0.1	0.2	(0.1)	PACE	0.4	0.4	0.0
4.1	**5.3**	**(1.1)**	**Operating**	**3.3**	**5.2**	**(1.9)**
1.5	1.3	0.2	Inv./Rental Inc, MCO tax	9.4	3.8	5.6
1.5	**1.3**	**0.2**	**Non-Operating**	**9.4**	**3.8**	**5.6**
5.6	**6.5**	**(0.9)**	**TOTAL**	**12.7**	**8.9**	**3.8**

Consolidated Revenue & Expense: September 2019 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	469,531	230,582	11,855	711,968	14,186	1,564	356	728,074
REVENUES								
Capitation Revenue	200,142,788	$ 146,129,939	$ 23,301,266	$ 369,573,994	$ 24,132,068	$ 1,828,294	$ 2,730,064	$ 398,264,420
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	200,142,788	146,129,939	23,301,266	369,573,994	24,132,068	1,828,294	2,730,064	398,264,420
MEDICAL EXPENSES								
Provider Capitation	39,831,132	46,365,275	8,076,462	94,272,868	11,313,633	492,799		106,079,300
Facilities	21,087,906	22,279,581	4,861,030	48,228,517	3,126,361	379,962	511,542	52,246,382
Ancillary	-	-	-	-	585,907	27,360	-	613,268
Professional Claims	14,271,472	7,163,498	1,907,376	23,342,346	-	-	514,647	23,856,993
Prescription Drugs	17,215,263	19,119,448	5,598,978	41,933,689	5,288,089	475,142	227,675	47,924,595
MLTSS	32,932,047	2,676,931	1,692,990	37,301,968	1,319,399	4,019	30,817	38,656,203
Medical Management	1,954,091	1,070,515	244,689	3,269,296	970,891	33,866	702,943	4,976,995
Quality Incentives	839,867	470,861	52,656	1,363,384	269,920		4,450	1,637,754
Reinsurance & Other	61,605,242	44,904,434	31,575	106,541,251	252,832		446,959	107,241,042
Total Medical Expenses	189,737,021	144,050,543	22,465,755	356,253,319	23,127,031	1,413,149	2,439,033	383,232,533
Medical Loss Ratio	94.8%	98.6%	96.4%	96.4%	95.8%	77.3%	89.3%	96.2%
GROSS MARGIN	**10,405,767**	**2,079,397**	**835,511**	**13,320,675**	**1,005,036**	**415,146**	**291,031**	**15,031,887**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,139,434	673,935	59,120	129,573	7,002,062
Professional fees				305,950	205,813	15,000	220	526,983
Purchased services				693,038	182,025	18,652	11,758	905,473
Printing & Postage				288,326	114,807	19,302	6	422,441
Depreciation & Amortization				366,016			2,092	368,108
Other expenses				1,281,154	35,061	348	5,108	1,321,671
Indirect cost allocation & Occupancy				(294,185)	578,548	48,860	22,581	355,804
Total Administrative Expenses				8,779,733	1,790,189	161,282	171,338	10,902,541
Admin Loss Ratio				2.4%	7.4%	8.8%	6.3%	2.7%
INCOME (LOSS) FROM OPERATIONS				4,540,942	(785,153)	253,864	119,693	4,129,347
INVESTMENT INCOME								1,473,295
NET RENTAL INCOME								1
TOTAL GRANT INCOME				151				151
OTHER INCOME				120				120
CHANGE IN NET ASSETS				**$ 4,541,213**	**$ (785,153)**	**$ 253,864**	**$ 119,693**	**$ 5,602,913**
BUDGETED CHANGE IN NET ASSETS				6,214,458	(1,061,738)	(82,449)	199,860	6,520,131
VARIANCE TO BUDGET - FAV (UNFAV)				$ (1,673,245)	$ 276,585	$ 336,313	$ (80,167)	$ (917,218)

Back to Agenda

Consolidated Revenue & Expense: September 2019 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,463,810	698,257	35,724	2,197,791	42,533	4,639	1,036	2,245,999
REVENUES								
Capitation Revenue	488,424,669	$ 352,892,873	$ 70,054,269	$ 911,371,811	$ 73,803,816	$ 5,475,007	$ 8,096,139	$ 998,746,772
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	488,424,669	352,892,873	70,054,269	911,371,811	73,803,816	5,475,007	8,096,139	998,746,772
MEDICAL EXPENSES								
Provider Capitation	118,181,074	136,053,499	28,453,314	282,687,887	33,516,813	1,437,817		317,642,516
Facilities	70,102,658	68,537,089	11,537,467	150,177,215	11,063,789	1,138,984	2,101,066	164,481,053
Ancillary	-	-	-	-	1,961,240	131,119	-	2,092,358
Professional Claims	50,474,996	23,646,937	4,337,916	78,459,849	-	-	1,604,193	80,064,042
Prescription Drugs	52,115,664	61,674,062	18,537,391	132,327,117	16,650,099	1,516,011	652,563	151,145,790
MLTSS	100,737,474	8,221,761	2,842,782	111,802,017	4,155,598	22,556	92,342	116,072,513
Medical Management	6,079,664	3,415,077	778,090	10,272,830	3,132,077	118,308	2,050,564	15,573,779
Quality Incentives	2,537,536	1,415,531	424,849	4,377,915	821,340		13,312	5,212,567
Reinsurance & Other	62,802,458	45,913,876	72,948	108,789,282	504,959		677,585	109,971,825
Total Medical Expenses	463,031,523	348,877,832	66,984,756	878,894,112	71,805,913	4,364,794	7,191,624	962,256,443
Medical Loss Ratio	94.8%	98.9%	95.6%	96.4%	97.3%	79.7%	88.8%	96.3%
GROSS MARGIN	**25,393,146**	**4,015,040**	**3,069,513**	**32,477,699**	**1,997,903**	**1,110,213**	**904,514**	**36,490,329**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				18,648,526	2,114,229	165,870	410,837	21,339,461
Professional fees				584,603	184,344	45,000	469	814,416
Purchased services				2,411,682	549,845	54,187	38,268	3,053,982
Printing & Postage				808,732	182,344	14,438	734	1,006,247
Depreciation & Amortization				1,165,857			6,276	1,172,133
Other expenses				4,605,920	12,810	348	10,146	4,629,224
Indirect cost allocation & Occupancy				(598,242)	1,618,132	120,038	29,908	1,169,836
Total Administrative Expenses				27,627,077	4,661,704	399,880	496,638	33,185,300
Admin Loss Ratio				3.0%	6.3%	7.3%	6.1%	3.3%
INCOME (LOSS) FROM OPERATIONS				4,850,622	(2,663,801)	710,333	407,876	3,305,029
INVESTMENT INCOME								9,382,387
OTHER INCOME				135				135
CHANGE IN NET ASSETS				**$ 4,850,756**	**$ (2,663,801)**	**$ 710,333**	**$ 407,876**	**$ 12,687,552**
BUDGETED CHANGE IN NET ASSETS				9,351,427	(4,169,221)	(372,636)	358,321	8,917,891
VARIANCE TO BUDGET - FAV (UNFAV)				$ (4,500,671)	$ 1,505,420	$ 1,082,969	$ 49,555	$ 3,769,661

Back to Agenda

Balance Sheet:
As of September 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$500,678,412	Accounts Payable	$7,116,206
Investments	535,432,042	Medical Claims liability	851,608,110
Capitation receivable	293,984,727	Accrued Payroll Liabilities	12,895,520
Receivables - Other	41,164,739	Deferred Revenue	39,410,686
Prepaid expenses	6,028,459	Deferred Lease Obligations	25,435
		Capitation and Withholds	143,835,203
Total Current Assets	**1,377,288,379**	**Total Current Liabilities**	**1,054,891,161**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	9,064,987		
505 City Parkway West	50,489,717		
	96,641,069		
Less: accumulated depreciation	(48,301,741)		
Capital assets, net	48,339,329	Other (than pensions) post employment benefits liability	25,069,864
Other Assets		Net Pension Liabilities	23,500,744
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,103,461,768**
Cash and Cash Equivalents	2,485,421		
Long-term Investments	561,396,534	Deferred Inflows	
Total Board-designated Assets	563,881,955	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	622,380,868	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,048,008,576**	TNE	108,304,218
		Funds in Excess of TNE	839,926,204
Deferred Outflows		**TOTAL NET POSITION**	948,230,422
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,059,099,025**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,059,099,025**

Back to Agenda

Board Designated Reserve and TNE Analysis
As of September 2019

Type	Reserve Name	Market Value	Benchmark		Variance		
			Low	High	Mkt - Low		Mkt - High
	Tier 1 - Payden & Rygel	154,563,989					
	Tier 1 - Logan Circle	153,378,677					
	Tier 1 - Wells Capital	153,827,568					
Board-designated Reserve		461,770,233	290,615,171	461,580,623	171,155,062		189,610
TNE Requirement	Tier 2 - Logan Circle	102,111,721	108,304,218	108,304,218	(6,192,496)	*	(6,192,496)
	Consolidated:	**563,881,955**	**398,919,389**	**569,884,841**	**164,962,566**		**(6,002,886)**
	Current reserve level	*1.98*	*1.40*	*2.00*			

*Note: Minimum TNE requirement increased in September due to PY Directed Payments included in medical expense per DHCS instruction.

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

September 2019

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2019

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
728,074	749,372	(21,298)	(2.8%)	Member Months	2,245,999	2,253,289	(7,290)	(0.3%)
398,264,420	297,453,331	100,811,089	33.9%	Revenues	998,746,772	892,785,343	105,961,429	11.9%
383,232,533	279,530,367	(103,702,165)	(37.1%)	Medical Expenses	962,256,443	848,487,225	(113,769,218)	(13.4%)
10,902,541	12,652,832	1,750,291	13.8%	Administrative Expenses	33,185,300	39,130,227	5,944,927	15.2%
4,129,347	**5,270,131**	**(1,140,785)**	**(21.6%)**	**Operating Margin**	**3,305,029**	**5,167,891**	**(1,862,862)**	**(36.0%)**
1,473,566	1,250,000	223,566	17.9%	Non Operating Income (Loss)	9,382,523	3,750,000	5,632,523	150.2%
5,602,913	**6,520,131**	**(917,218)**	**(14.1%)**	**Change in Net Assets**	**12,687,552**	**8,917,891**	**3,769,661**	**42.3%**
96.2%	94.0%	(2.3%)		Medical Loss Ratio	96.3%	95.0%	(1.3%)	
2.7%	4.3%	1.5%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
1.0%	1.8%	(0.7%)		Operating Margin Ratio	0.3%	0.6%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%	4.3%	0.5%		Administrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the categorization of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2019

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	711,968	733,384	(21,416)	(2 9%)
OneCare Connect	14,186	14,135	51	0 4%
OneCare	1,564	1,498	66	4 4%
PACE	356	355	1	0 3%
Total	728,074	749,372	(21,298)	(2 8%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,541	$ 6,214	$ (1,673)	(26 9%)
OneCare Connect	(785)	(1,062)	277	26 1%
OneCare	254	(82)	336	409 8%
PACE	120	200	(80)	(40 0%)
505 Bldg	-	-	-	0 0%
Investment Income & Other	1,473	1,250	223	17 8%
Total	$ 5,603	$ 6,520	$ (917)	(14 1%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 4%	93 8%	(2 6)
OneCare Connect	95 8%	96 9%	1 1
OneCare	77 3%	96 2%	18 9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,780	$ 10,537	$ 1,758	16 7%
OneCare Connect	1,790	1,793	3	0 2%
OneCare	161	145	(16)	(11 1%)
PACE	171	177	6	3 4%
Total	$ 10,903	$ 12,653	$ 1,750	13 8%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	955	1,145	191
OneCare Connect	172	200	27
OneCare	9	9	0
PACE	73	93	19
Total	1,210	1,447	237

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	746	640	105
OneCare Connect	82	71	12
OneCare	172	161	11
PACE	5	4	1
Total	1,005	876	129

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,197,791	2,205,230	(7,439)	(0 3%)
OneCare Connect	42,533	42,527	6	0 0%
OneCare	4,639	4,488	151	3 4%
PACE	1,036	1,044	(8)	(0 8%)
Total	2,245,999	2,253,289	(7,290)	(0 3%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,851	$ 9,351	$ (4,500)	(48 1%)
OneCare Connect	(2,664)	(4,169)	1,505	36 1%
OneCare	710	(373)	1,083	290 3%
PACE	408	358	50	14 0%
505 Bldg	-	-	-	0 0%
Investment Income & Other	9,383	3,750	5,633	150 2%
Total	$ 12,688	$ 8,917	$ 3,771	42 3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 4%	94 8%	(1 6)
OneCare Connect	97 3%	98 1%	0 9
OneCare	79 7%	98 5%	18 8

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 27,627	$ 32,634	$ 5,007	15 3%
OneCare Connect	4,662	5,499	837	15 2%
OneCare	400	444	44	9 9%
PACE	497	554	57	10 3%
Total	$ 33,185	$ 39,130	$ 5,945	15 2%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,802	3,436	634
OneCare Connect	545	599	54
OneCare	21	28	7
PACE	213	274	60
Total	3,581	4,337	756

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	784	642	143
OneCare Connect	78	71	7
OneCare	219	161	58
PACE	5	4	1
Total	1,086	877	209

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended September 30, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	728,074		749,372		(21,298)	
REVENUE						
Medi-Cal	$ 369,573,994	$ 519 09	$ 269,143,127	$ 366 99	$ 100,430,868	$ 152 10
OneCare Connect	24,132,068	1,701 12	23,901,753	1,690 96	230,315	10 16
OneCare	1,828,294	1,168 99	1,648,085	1,100 19	180,209	68 80
PACE	2,730,064	7,668 72	2,760,366	7,775 68	(30,302)	(106 96)
Total Operating Revenue	398,264,420	547 01	297,453,331	396 94	100,811,089	150 07
MEDICAL EXPENSES						
Medi-Cal	356,253,319	500 38	252,391,302	344 15	(103,862,017)	(156 23)
OneCare Connect	23,127,031	1,630 27	23,170,540	1,639 23	43,509	8 96
OneCare	1,413,149	903 55	1,585,401	1,058 35	172,252	154 80
PACE	2,439,033	6,851 22	2,383,124	6,713 03	(55,909)	(138 19)
Total Medical Expenses	383,232,533	526 36	279,530,367	373 02	(103,702,165)	(153 34)
GROSS MARGIN	15,031,887	20 65	17,922,963	23 92	(2,891,076)	(3 27)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,002,062	9 62	7,810,803	10 42	808,741	0 80
Professional fees	526,983	0 72	473,968	0 63	(53,015)	(0 09)
Purchased services	905,473	1 24	1,233,276	1 65	327,803	0 41
Printing & Postage	422,441	0 58	565,973	0 76	143,532	0 18
Depreciation & Amortization	368,108	0 51	457,866	0 61	89,758	0 10
Other expenses	1,321,671	1 82	1,726,059	2 30	404,388	0 48
Indirect cost allocation & Occupancy expense	355,804	0 49	384,887	0 51	29,083	0 02
Total Administrative Expenses	10,902,541	14 97	12,652,832	16 88	1,750,291	1 91
INCOME (LOSS) FROM OPERATIONS	4,129,347	5 67	5,270,131	7 03	(1,140,785)	(1 36)
INVESTMENT INCOME						
Interest income	2,890,406	3 97	1,250,000	1 67	1,640,406	2 30
Realized gain/(loss) on investments	108,160	0 15	-	-	108,160	0 15
Unrealized gain/(loss) on investments	(1,525,271)	(2 09)	-	-	(1,525,271)	(2 09)
Total Investment Income	1,473,295	2 02	1,250,000	1 67	223,295	0 35
NET RENTAL INCOME	1	-	-	-	1	-
TOTAL GRANT INCOME	151	-	-	-	151	-
OTHER INCOME	120	-	-	-	120	-
CHANGE IN NET ASSETS	**5,602,913**	**7.70**	**6,520,131**	**8.70**	**(917,218)**	**(1.00)**
MEDICAL LOSS RATIO	**96.2%**		**94.0%**		**-2.3%**	
ADMINISTRATIVE LOSS RATIO	**2.7%**		**4.3%**		**1.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2019

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	2,245,999		2,253,289		(7,290)	
REVENUE						
Medi-Cal	$ 911,371,811	$ 414.68	$ 808,178,311	$ 366.48	$ 103,193,500	$ 48.20
OneCare Connect	73,803,816	1,735.21	71,599,271	1,683.66	2,204,545	51.55
OneCare	5,475,007	1,180.21	4,884,698	1,088.39	590,309	91.82
PACE	8,096,139	7,814.81	8,123,063	7,780.71	(26,924)	34.10
Total Operating Revenue	998,746,772	444.68	892,785,343	396.21	105,961,429	48.47
MEDICAL EXPENSES						
Medi-Cal	878,894,112	399.90	766,192,852	347.44	(112,701,260)	(52.46)
OneCare Connect	71,805,913	1,688.24	70,269,873	1,652.40	(1,536,040)	(35.84)
OneCare	4,364,794	940.89	4,813,672	1,072.57	448,878	131.68
PACE	7,191,624	6,941.72	7,210,828	6,906.92	19,204	(34.80)
Total Medical Expenses	962,256,443	428.43	848,487,225	376.55	(113,769,218)	(51.88)
GROSS MARGIN	36,490,329	16.25	44,298,118	19.66	(7,807,789)	(3.41)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	21,339,461	9.50	24,655,315	10.94	3,315,854	1.44
Professional fees	814,416	0.36	1,379,571	0.61	565,155	0.25
Purchased services	3,053,982	1.36	3,699,828	1.64	645,846	0.28
Printing & Postage	1,006,247	0.45	1,697,233	0.75	690,986	0.30
Depreciation & Amortization	1,172,133	0.52	1,373,598	0.61	201,465	0.09
Other expenses	4,629,224	2.06	5,166,955	2.29	537,731	0.23
Indirect cost allocation & Occupancy expense	1,169,836	0.52	1,157,727	0.51	(12,109)	(0.01)
Total Administrative Expenses	33,185,300	14.78	39,130,227	17.37	5,944,927	2.59
INCOME (LOSS) FROM OPERATIONS	3,305,029	1.47	5,167,891	2.29	(1,862,862)	(0.82)
INVESTMENT INCOME						
Interest income	8,894,086	3.96	3,750,000	1.66	5,144,086	2.30
Realized gain/(loss) on investments	802,340	0.36	-	-	802,340	0.36
Unrealized gain/(loss) on investments	(314,038)	(0.14)	-	-	(314,038)	(0.14)
Total Investment Income	9,382,387	4.18	3,750,000	1.66	5,632,387	2.52
OTHER INCOME	135	-	-	-	135	-
CHANGE IN NET ASSETS	**12,687,552**	**5.65**	**8,917,891**	**3.96**	**3,769,661**	**1.69**
MEDICAL LOSS RATIO	**96.3%**		**95.0%**		**-1.3%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.4%**		**1.1%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	469,531	230,582	11,855	711,968	14,186	1,564	356	728,074
REVENUES								
Capitation Revenue	200,142,788	$ 146,129,939	$ 23,301,266	$ 369,573,994	$ 24,132,068	$ 1,828,294	$ 2,730,064	$ 398,264,420
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	200,142,788	146,129,939	23,301,266	369,573,994	24,132,068	1,828,294	2,730,064	398,264,420
MEDICAL EXPENSES								
Provider Capitation	39,831,132	46,365,275	8,076,462	94,272,868	11,313,633	492,799		106,079,300
Facilities	21,087,906	22,279,581	4,861,030	48,228,517	3,126,361	379,962	511,542	52,246,382
Ancillary	-	-	-	-	585,907	27,360	-	613,268
Professional Claims	14,271,472	7,163,498	1,907,376	23,342,346	-	-	514,647	23,856,993
Prescription Drugs	17,215,263	19,119,448	5,598,978	41,933,689	5,288,089	475,142	227,675	47,924,595
MLTSS	32,932,047	2,676,931	1,692,990	37,301,968	1,319,399	4,019	30,817	38,656,203
Medical Management	1,954,091	1,070,515	244,689	3,269,296	970,891	33,866	702,943	4,976,995
Quality Incentives	839,867	470,861	52,656	1,363,384	269,920		4,450	1,637,754
Reinsurance & Other	61,605,242	44,904,434	31,575	106,541,251	252,832		446,959	107,241,042
Total Medical Expenses	189,737,021	144,050,543	22,465,755	356,253,319	23,127,031	1,413,149	2,439,033	383,232,533
Medical Loss Ratio	94 8%	98 6%	96 4%	96 4%	95 8%	77 3%	89 3%	96 2%
GROSS MARGIN	**10,405,767**	**2,079,397**	**835,511**	**13,320,675**	**1,005,036**	**415,146**	**291,031**	**15,031,887**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,139,434	673,935	59,120	129,573	7,002,062
Professional fees				305,950	205,813	15,000	220	526,983
Purchased services				693,038	182,025	18,652	11,758	905,473
Printing & Postage				288,326	114,807	19,302	6	422,441
Depreciation & Amortization				366,016			2,092	368,108
Other expenses				1,281,154	35,061	348	5,108	1,321,671
Indirect cost allocation & Occupancy				(294,185)	578,548	48,860	22,581	355,804
Total Administrative Expenses				8,779,733	1,790,189	161,282	171,338	10,902,541
Admin Loss Ratio				2 4%	7 4%	8 8%	6 3%	2 7%
INCOME (LOSS) FROM OPERATIONS				4,540,942	(785,153)	253,864	119,693	4,129,347
INVESTMENT INCOME								1,473,295
NET RENTAL INCOME								1
TOTAL GRANT INCOME				151				151
OTHER INCOME				120				120
CHANGE IN NET ASSETS				**$ 4,541,213**	**$ (785,153)**	**$ 253,864**	**$ 119,693**	**$ 5,602,913**
BUDGETED CHANGE IN NET ASSETS				6,214,458	(1,061,738)	(82,449)	199,860	6,520,131
VARIANCE TO BUDGET - FAV (UNFAV)				$ (1,673,245)	$ 276,585	$ 336,313	$ (80,167)	$ (917,218)

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2019

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,463,810	698,257	35,724	2,197,791	42,533	4,639	1,036	2,245,999
REVENUES								
Capitation Revenue	488,424,669	$ 352,892,873	$ 70,054,269	$ 911,371,811	$ 73,803,816	$ 5,475,007	$ 8,096,139	$ 998,746,772
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	488,424,669	352,892,873	70,054,269	911,371,811	73,803,816	5,475,007	8,096,139	998,746,772
MEDICAL EXPENSES								
Provider Capitation	118,181,074	136,053,499	28,453,314	282,687,887	33,516,813	1,437,817		317,642,516
Facilities	70,102,658	68,537,089	11,537,467	150,177,215	11,063,789	1,138,984	2,101,066	164,481,053
Ancillary	-	-	-	-	1,961,240	131,119	-	2,092,358
Professional Claims	50,474,996	23,646,937	4,337,916	78,459,849	-	-	1,604,193	80,064,042
Prescription Drugs	52,115,664	61,674,062	18,537,391	132,327,117	16,650,099	1,516,011	652,563	151,145,790
MLTSS	100,737,474	8,221,761	2,842,782	111,802,017	4,155,598	22,556	92,342	116,072,513
Medical Management	6,079,664	3,415,077	778,090	10,272,830	3,132,077	118,308	2,050,564	15,573,779
Quality Incentives	2,537,536	1,415,531	424,849	4,377,915	821,340		13,312	5,212,567
Reinsurance & Other	62,802,458	45,913,876	72,948	108,789,282	504,959		677,585	109,971,825
Total Medical Expenses	463,031,523	348,877,832	66,984,756	878,894,112	71,805,913	4,364,794	7,191,624	962,256,443
Medical Loss Ratio	94 8%	98 9%	95 6%	96 4%	97 3%	79 7%	88 8%	96 3%
GROSS MARGIN	**25,393,146**	**4,015,040**	**3,069,513**	**32,477,699**	**1,997,903**	**1,110,213**	**904,514**	**36,490,329**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				18,648,526	2,114,229	165,870	410,837	21,339,461
Professional fees				584,603	184,344	45,000	469	814,416
Purchased services				2,411,682	549,845	54,187	38,268	3,053,982
Printing & Postage				808,732	182,344	14,438	734	1,006,247
Depreciation & Amortization				1,165,857			6,276	1,172,133
Other expenses				4,605,920	12,810	348	10,146	4,629,224
Indirect cost allocation & Occupancy				(598,242)	1,618,132	120,038	29,908	1,169,836
Total Administrative Expenses				27,627,077	4,661,704	399,880	496,638	33,185,300
Admin Loss Ratio				3 0%	6 3%	7 3%	6 1%	3 3%
INCOME (LOSS) FROM OPERATIONS				4,850,622	(2,663,801)	710,333	407,876	3,305,029
INVESTMENT INCOME								9,382,387
OTHER INCOME				135				135
CHANGE IN NET ASSETS				**$ 4,850,756**	**$ (2,663,801)**	**$ 710,333**	**$ 407,876**	**$ 12,687,552**
BUDGETED CHANGE IN NET ASSETS				9,351,427	(4,169,221)	(372,636)	358,321	8,917,891
VARIANCE TO BUDGET - FAV (UNFAV)				$ (4,500,671)	$ 1,505,420	$ 1,082,969	$ 49,555	$ 3,769,661

September 30, 2019 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $5.6 million, $0.9 million unfavorable to budget
- Operating surplus is $4.1 million, with a surplus in non-operating income of $1.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $12.7 million, $3.8 million favorable to budget
- Operating surplus is $3.3 million, with a surplus in non-operating income of $9.4 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	6.2	(1.7)	Medi-Cal	4.9	9.4	(4.5)
(0.8)	(1.1)	0.3	OCC	(2.7)	(4.2)	1.5
0.3	(0.1)	0.3	OneCare	0.7	(0.4)	1.1
0.1	0.2	(0.1)	PACE	0.4	0.4	0.0
4.1	**5.3**	**(1.1)**	**Operating**	**3.3**	**5.2**	**(1.9)**
1.5	1.3	0.2	Inv./Rental Inc, MCO tax	9.4	3.8	5.6
1.5	**1.3**	**0.2**	**Non-Operating**	**9.4**	**3.8**	**5.6**
5.6	**6.5**	**(0.9)**	**TOTAL**	**12.7**	**8.9**	**3.8**

CalOptima - Consolidated
Enrollment Summary
For the Three Months Ended September 30, 2019

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
65,215	65,451	(236)	(0.4%)	Aged	195,935	195,959	(24)	(0.0%)
503	615	(112)	(18.2%)	BCCTP	1,630	1,845	(215)	(11.7%)
43,999	43,796	203	0.5%	Disabled	133,994	131,493	2,501	1.9%
269,741	284,825	(15,084)	(5.3%)	TANF Child*	857,654	858,645	(991)	(0.1%)
86,674	87,135	(461)	(0.5%)	TANF Adult	264,396	262,865	1,531	0.6%
3,399	3,404	(5)	(0.1%)	LTC	10,201	10,212	(11)	(0.1%)
230,582	235,218	(4,636)	(2.0%)	MCE	698,257	705,391	(7,134)	(1.0%)
11,855	12,940	(1,085)	(8.4%)	WCM**	35,724	38,820	(3,096)	(8.0%)
711,968	**733,384**	**(21,416)**	**(2.9%)**	**Medi-Cal**	**2,197,791**	**2,205,230**	**(7,439)**	**(0.3%)**
14,186	**14,135**	**51**	**0.4%**	**OneCare Connect**	**42,533**	**42,527**	**6**	**0.0%**
1,564	**1,498**	**66**	**4.4%**	**OneCare**	**4,639**	**4,488**	**151**	**3.4%**
356	**355**	**1**	**0.3%**	**PACE**	**1,036**	**1,044**	**(8)**	**(0.8%)**
728,074	**749,372**	**(21,298)**	**(2.8%)**	**CalOptima Total**	**2,245,999**	**2,253,289**	**(7,290)**	**(0.3%)**

* TANF Child actuals include approximatley 13.8 thousand prior year adjustments

** WCM was budgeted based on initial implementation date. Enrollment for WCM was transferred from the other seven aid categories.

				Enrollment (By Network)				
161,178	162,685	(1,507)	(0.9%)	HMO	487,328	489,117	(1,789)	(0.4%)
206,041	210,189	(4,148)	(2.0%)	PHC	628,785	632,678	(3,893)	(0.6%)
179,572	187,955	(8,383)	(4.5%)	Shared Risk Group	555,935	565,297	(9,362)	(1.7%)
165,177	172,555	(7,378)	(4.3%)	Fee for Service	525,743	518,138	7,605	1.5%
711,968	**733,384**	**(21,416)**	**(2.9%)**	**Medi-Cal**	**2,197,791**	**2,205,230**	**(7,439)**	**(0.3%)**
14,186	**14,135**	**51**	**0.4%**	**OneCare Connect**	**42,533**	**42,527**	**6**	**0.0%**
1,564	**1,498**	**66**	**4.4%**	**OneCare**	**4,639**	**4,488**	**151**	**3.4%**
356	**355**	**1**	**0.3%**	**PACE**	**1,036**	**1,044**	**(8)**	**(0.8%)**
728,074	**749,372**	**(21,298)**	**(2.8%)**	**CalOptima Total**	**2,245,999**	**2,253,289**	**(7,290)**	**(0.3%)**

CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2020

Network Type	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	MMs
HMO													
Aged	3,723	3,740	3,754										11,217
BCCTP	1	1	2										4
Disabled	6,539	6,547	6,572										19,658
TANF Child	54,046	53,703	52,620										160,369
TANF Adult	27,944	27,740	27,446										83,130
LTC	2	1	3										6
MCE	68,973	69,077	68,729										206,779
WCM	2,026	2,087	2,052										6,165
	163,254	**162,896**	**161,178**										**487,328**
PHC													
Aged	1,548	1,540	1,524										4,612
BCCTP	-	-	-										-
Disabled	5,416	5,499	5,323										16,238
TANF Child	148,665	148,131	143,994										440,790
TANF Adult	11,149	11,322	10,925										33,396
LTC	-	-	1										1
MCE	37,510	37,479	37,084										112,073
WCM	7,209	7,276	7,190										21,675
	211,497	**211,247**	**206,041**										**628,785**
Shared Risk Group													
Aged	3,569	3,523	3,470										10,562
BCCTP	-	-	-										-
Disabled	7,275	7,294	7,144										21,713
TANF Child	63,291	62,381	57,001										182,673
TANF Adult	28,681	28,390	27,842										84,913
LTC	1	3	3										7
MCE	84,595	83,922	82,492										251,009
WCM	1,732	1,706	1,620										5,058
	189,144	**187,219**	**179,572**										**555,935**
Fee for Service (Dual)													
Aged	51,730	52,454	52,097										156,281
BCCTP	15	18	17										50
Disabled	20,752	20,053	20,586										61,391
TANF Child	-	19	1										20
TANF Adult	964	1,923	949										3,836
LTC	3,044	3,097	3,061										9,202
MCE	2,116	2,171	1,935										6,222
WCM	15	15	15										45
	78,636	**79,750**	**78,661**										**237,047**
Fee for Service (Non-Dual)													
Aged	4,682	4,211	4,370										13,263
BCCTP	550	542	484										1,576
Disabled	4,928	5,692	4,374										14,994
TANF Child	25,571	32,106	16,125										73,802
TANF Adult	19,658	19,951	19,512										59,121
LTC	328	326	331										985
MCE	40,680	41,152	40,342										122,174
WCM	843	960	978										2,781
	97,240	**104,940**	**86,516**										**288,696**
MEDI-CAL TOTAL													
Aged	65,252	65,468	65,215										195,935
BCCTP	566	561	503										1,630
Disabled	44,910	45,085	43,999										133,994
TANF Child	291,573	296,340	269,741										857,654
TANF Adult	88,396	89,326	86,674										264,396
LTC	3,375	3,427	3,399										10,201
MCE	233,874	233,801	230,582										698,257
WCM	11,825	12,044	11,855										35,724
	739,771	**746,052**	**711,968**										**2,197,791**
OneCare Connect	14,257	14,090	14,186										42,533
OneCare	1,530	1,545	1,564										4,639
PACE	335	345	356										1,036
TOTAL	**755,893**	**762,032**	**728,074**										**2,245,999**

ENROLLMENT:

Overall September enrollment was 728,074

- Unfavorable to budget 21,298 or 2.8%. September enrollment includes prior year (PY) retroactive disenrollment of 16,942 members due a correction of member eligibility logic
- Decreased 33,958 or 4.5% from prior month (August 2019)
- Decreased 46,366 or 6.0% from PY (September 2018)

Medi-Cal enrollment was 711,968

- Unfavorable to budget 21,416 or 2.9%
  - Temporary Assistance for Needy Families (TANF) unfavorable 15,545
  - Medi-Cal Expansion (MCE) unfavorable 4,636
  - Whole Child Model (WCM) unfavorable 1,085
  - Seniors and Persons with Disabilities (SPD) unfavorable 145
  - Long-Term Care (LTC) unfavorable 5
- Decreased 34,084 from prior month

OneCare Connect enrollment was 14,186

- Favorable to budget 51 or 0.4%
- Increased 96 from prior month

OneCare enrollment was 1,564

- Favorable to budget 66 or 4.4%
- Increased 19 from prior month

PACE enrollment was 356

- Favorable to budget 1 or 0.3%
- Increased 11 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
711,968	**733,384**	**(21,416)**	**(2.9%)**	**Member Months**	**2,197,791**	**2,205,230**	**(7,439)**	**(0.3%)**
				Revenues				
369,573,994	269,143,127	100,430,868	37 3%	Capitation revenue	911,371,811	808,178,311	103,193,500	12 8%
-	-	-	0 0%	Other income	-	-	-	0 0%
369,573,994	**269,143,127**	**100,430,868**	**37.3%**	**Total Operating Revenue**	**911,371,811**	**808,178,311**	**103,193,500**	**12.8%**
				Medical Expenses				
95,636,252	95,202,800	(433,452)	(0 5%)	Provider capitation	287,065,802	286,092,573	(973,228)	(0 3%)
48,228,517	47,537,141	(691,375)	(1 5%)	Facilities	150,177,215	144,691,739	(5,485,476)	(3 8%)
23,342,346	22,632,615	(709,731)	(3 1%)	Professional Claims	78,459,849	69,136,451	(9,323,398)	(13 5%)
41,933,689	43,226,900	1,293,211	3 0%	Prescription drugs	132,327,117	132,047,515	(279,603)	(0 2%)
37,301,968	36,323,258	(978,710)	(2 7%)	MLTSS	111,802,017	111,195,611	(606,406)	(0 5%)
3,269,296	4,291,708	1,022,412	23 8%	Medical management	10,272,830	13,441,032	3,168,202	23 6%
106,541,251	3,176,880	(103,364,372)	(3253 6%)	Reinsurance & other	108,789,282	9,587,931	(99,201,351)	(1034 6%)
356,253,319	**252,391,302**	**(103,862,017)**	**(41.2%)**	**Total Medical Expenses**	**878,894,112**	**766,192,852**	**(112,701,260)**	**(14.7%)**
13,320,675	**16,751,824**	**(3,431,149)**	**(20.5%)**	**Gross Margin**	**32,477,699**	**41,985,459**	**(9,507,760)**	**(22.6%)**
				Administrative Expenses				
6,139,434	6,839,068	699,634	10 2%	Salaries, wages & employee benefits	18,648,526	21,590,180	2,941,654	13 6%
305,950	374,539	68,589	18 3%	Professional fees	584,603	1,081,284	496,681	45 9%
693,038	954,254	261,216	27 4%	Purchased services	2,411,682	2,862,760	451,078	15 8%
288,326	442,912	154,586	34 9%	Printing and postage	808,732	1,328,052	519,320	39 1%
366,016	455,750	89,734	19 7%	Depreciation and amortization	1,165,857	1,367,250	201,393	14 7%
1,281,154	1,645,295	364,141	22 1%	Other operating expenses	4,605,920	4,924,668	318,748	6 5%
(294,185)	(174,452)	119,733	68 6%	Indirect cost allocation, Occupancy Expense	(598,242)	(520,162)	78,080	15 0%
8,779,733	**10,537,366**	**1,757,633**	**16.7%**	**Total Administrative Expenses**	**27,627,077**	**32,634,032**	**5,006,955**	**15.3%**
				Operating Tax				
-	11,306,809	(11,306,809)	(100 0%)	Tax Revenue	-	33,997,358	(33,997,358)	(100 0%)
-	11,306,809	11,306,809	100 0%	Premium tax expense	-	33,997,358	33,997,358	100 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
9,933	-	9,933	0 0%	Grant Revenue	28,526	-	28,526	0 0%
(63)	-	63	0 0%	Grant expense - Service Partner	(63)	-	63	0 0%
9,845	-	(9,845)	0 0%	Grant expense - Administrative	28,589	-	(28,589)	0 0%
151	-	151	**0.0%**	**Total Grant Income**	(0)	-	(0)	**0.0%**
120	**-**	**120**	**0.0%**	**Other income**	**135**	**-**	**135**	**0.0%**
4,541,213	**6,214,458**	**(1,673,245)**	**(26.9%)**	**Change in Net Assets**	**4,850,756**	**9,351,427**	**(4,500,671)**	**(48.1%)**
96.4%	***93.8%***	***(2.6%)***	***(2.8%)***	***Medical Loss Ratio***	***96.4%***	***94.8%***	***(1.6%)***	***(1.7%)***
2.4%	***3.9%***	***1.5%***	***39.3%***	***Admin Loss Ratio***	***3.0%***	***4.0%***	***1.0%***	***24.9%***

MEDI-CAL INCOME STATEMENT - SEPTEMBER MONTH:

REVENUES of $369.6 million are favorable to budget $100.4 million driven by:

- Unfavorable volume related variance of $7.9 million
- Favorable price related variance of $108.3 million due to:
  - ➢ $104.3 million of Directed Payments (DP) revenue
  - ➢ $3.0 million of Coordinated Care Initiative (CCI) revenue

MEDICAL EXPENSES of $356.3 million are unfavorable to budget $103.9 million driven by:

- ❖ Due to claim lag and limited information available, most of WCM medical expenses were estimated based on budget assumptions in September 2019

- **Reinsurance and Other** expenses are unfavorable to budget $103.4 million related to DP expenses recognized
- **Prescription Drug** expense is favorable to budget $1.3 million
- **Medical Management** expense is favorable to budget $1.1 million

ADMINISTRATIVE EXPENSES of $8.8 million are favorable to budget $1.8 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.7 million due to open positions
- Other Non-Salary expenses are favorable to budget $1.1 million

CHANGE IN NET ASSETS is $4.5 million for the month, unfavorable to budget $1.7 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Three Months Ending September 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,186	**14,135**	**51**	**0.4%**	**Member Months**	**42,533**	**42,527**	**6**	**0.0%**
				Revenues				
2,441,000	2,792,271	(351,271)	(12 6%)	Medi-Cal Capitation revenue	7,250,050	8,413,144	(1,163,094)	(13 8%)
16,939,173	16,312,568	626,605	3 8%	Medicare Capitation revenue part C	50,597,134	48,801,279	1,795,855	3 7%
4,751,896	4,796,914	(45,018)	(0 9%)	Medicare Capitation revenue part D	15,956,631	14,384,848	1,571,783	10 9%
-	-	-	0 0%	Other Income	-	-	-	0 0%
24,132,068	**23,901,753**	**230,315**	**1.0%**	**Total Operating Revenue**	**73,803,816**	**71,599,271**	**2,204,545**	**3.1%**
				Medical Expenses				
11,583,553	10,972,584	(610,969)	(5 6%)	Provider capitation	34,338,153	32,886,066	(1,452,086)	(4 4%)
3,126,361	3,449,338	322,977	9 4%	Facilities	11,063,789	10,459,518	(604,271)	(5 8%)
585,907	666,088	80,181	12 0%	Ancillary	1,961,240	2,036,279	75,039	3 7%
1,319,399	1,525,281	205,882	13 5%	Long Term Care	4,155,598	4,693,974	538,376	11 5%
5,288,089	5,288,604	515	0 0%	Prescription drugs	16,650,099	16,234,079	(416,020)	(2 6%)
970,891	1,051,592	80,701	7 7%	Medical management	3,132,077	3,311,213	179,136	5 4%
252,832	217,053	(35,779)	(16 5%)	Other medical expenses	504,959	648,744	143,785	22 2%
23,127,031	**23,170,540**	**43,509**	**0.2%**	**Total Medical Expenses**	**71,805,913**	**70,269,873**	**(1,536,040)**	**(2.2%)**
1,005,036	**731,213**	**273,823**	**37.4%**	**Gross Margin**	**1,997,903**	**1,329,398**	**668,505**	**50.3%**
				Administrative Expenses				
673,935	784,625	110,690	14 1%	Salaries, wages & employee benefits	2,114,229	2,473,643	359,414	14 5%
205,813	77,796	(128,017)	(164 6%)	Professional fees	184,344	233,388	49,044	21 0%
182,025	242,988	60,963	25 1%	Purchased services	549,845	728,966	179,121	24 6%
114,807	95,861	(18,946)	(19 8%)	Printing and postage	182,344	287,581	105,237	36 6%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
35,061	71,889	36,828	51 2%	Other operating expenses	12,810	215,665	202,855	94 1%
578,548	519,792	(58,756)	(11 3%)	Indirect cost allocation	1,618,132	1,559,376	(58,756)	(3 8%)
1,790,189	**1,792,951**	**2,762**	**0.2%**	**Total Administrative Expenses**	**4,661,704**	**5,498,619**	**836,915**	**15.2%**
(785,153)	**(1,061,738)**	**276,585**	**26.1%**	**Change in Net Assets**	**(2,663,801)**	**(4,169,221)**	**1,505,420**	**36.1%**
95.8%	***96.9%***	***1.1%***	***1.1%***	***Medical Loss Ratio***	***97.3%***	***98.1%***	***0.9%***	***0.9%***
7.4%	***7.5%***	***0.1%***	***1.1%***	***Admin Loss Ratio***	***6.3%***	***7.7%***	***1.4%***	***17.8%***

ONECARE CONNECT INCOME STATEMENT - SEPTEMBER MONTH:

REVENUES of $24.1 million are favorable to budget $0.2 million driven by:

- Favorable volume related variance of $86.2 thousand
- Favorable price related variance of $0.1 million

MEDICAL EXPENSES of $23.1 million are in line with budget:

- Unfavorable volume related variance of $83.6 thousand
- Favorable price related variance of $0.1 million

ADMINISTRATIVE EXPENSES of $1.8 million are in line with budget

C**HANGE IN NET ASSETS** is ($0.8) million, favorable to budget $0.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,564	**1,498**	**66**	**4.4%**	**Member Months**	**4,639**	**4,488**	**151**	**3.4%**
				Revenues				
1,331,438	1,128,060	203,378	18 0%	Medicare Part C revenue	3,816,905	3,335,478	481,427	14 4%
496,856	520,025	(23,169)	(4 5%)	Medicare Part D revenue	1,658,102	1,549,220	108,882	7 0%
1,828,294	**1,648,085**	**180,209**	**10.9%**	**Total Operating Revenue**	**5,475,007**	**4,884,698**	**590,309**	**12.1%**
				Medical Expenses				
492,799	446,842	(45,957)	(10 3%)	Provider capitation	1,437,817	1,321,673	(116,144)	(8 8%)
379,962	493,765	113,803	23 0%	Inpatient	1,138,984	1,512,668	373,684	24 7%
27,360	53,968	26,608	49 3%	Ancillary	131,119	165,214	34,095	20 6%
4,019	44,318	40,299	90 9%	Skilled nursing facilities	22,556	135,725	113,169	83 4%
475,142	488,934	13,792	2 8%	Prescription drugs	1,516,011	1,500,734	(15,277)	(1 0%)
33,866	46,762	12,896	27 6%	Medical management	118,308	145,266	26,958	18 6%
-	10,812	10,812	100 0%	Other medical expenses	-	32,392	32,392	100 0%
1,413,149	**1,585,401**	**172,252**	**10.9%**	**Total Medical Expenses**	**4,364,794**	**4,813,672**	**448,878**	**9.3%**
415,146	**62,684**	**352,462**	**562.3%**	**Gross Margin**	**1,110,213**	**71,026**	**1,039,187**	**1463.1%**
				Administrative Expenses				
59,120	49,596	(9,524)	(19 2%)	Salaries, wages & employee benefits	165,870	157,051	(8,819)	(5 6%)
15,000	21,480	6,480	30 2%	Professional fees	45,000	64,440	19,440	30 2%
18,652	17,063	(1,589)	(9 3%)	Purchased services	54,187	51,189	(2,998)	(5 9%)
19,302	16,667	(2,635)	(15 8%)	Printing and postage	14,438	50,001	35,563	71 1%
348	4,738	4,390	92 7%	Other operating expenses	348	14,214	13,866	97 6%
48,860	35,589	(13,271)	(37 3%)	Indirect cost allocation, occupancy expense	120,038	106,767	(13,271)	(12 4%)
161,282	**145,133**	**(16,149)**	**(11.1%)**	**Total Administrative Expenses**	**399,880**	**443,662**	**43,782**	**9.9%**
253,864	**(82,449)**	**336,313**	**407.9%**	**Change in Net Assets**	**710,333**	**(372,636)**	**1,082,969**	**290.6%**
77.3%	***96.2%***	***18.9%***	***19.7%***	***Medical Loss Ratio***	***79.7%***	***98.5%***	***18.8%***	***19.1%***
8.8%	***8.8%***	***(0.0%)***	***(0.2%)***	***Admin Loss Ratio***	***7.3%***	***9.1%***	***1.8%***	***19.6%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
356	**355**	**1**	**0.3%**	**Member Months**	**1,036**	**1,044**	**(8)**	**-0.8%**
				Revenues				
2,237,963	2,133,191	104,772	4 9%	Medi-Cal capitation revenue	6,433,804	6,275,324	158,480	2 5%
377,978	495,978	(118,000)	(23 8%)	Medicare Part C revenue	1,301,816	1,462,310	(160,494)	(11 0%)
114,123	131,197	(17,074)	(13 0%)	Medicare Part D revenue	360,519	385,429	(24,910)	(6 5%)
2,730,064	**2,760,366**	**(30,302)**	**(1.1%)**	**Total Operating Revenue**	**8,096,139**	**8,123,063**	**(26,924)**	**(0.3%)**
				Medical Expenses				
702,943	854,171	151,228	17 7%	Medical Management	2,050,564	2,631,863	581,299	22 1%
511,542	508,610	(2,932)	(0 6%)	Claims payments to hospitals	2,101,066	1,525,860	(575,206)	(37 7%)
514,647	558,090	43,443	7 8%	Professional claims	1,604,193	1,675,512	71,319	4 3%
446,959	221,100	(225,859)	(102 2%)	Patient transportation	677,585	658,974	(18,611)	(2 8%)
227,675	212,104	(15,571)	(7 3%)	Prescription drugs	652,563	636,349	(16,214)	(2 5%)
30,817	22,383	(8,434)	(37 7%)	MLTSS	92,342	62,270	(30,072)	(48 3%)
4,450	6,666	2,216	33 2%	Other Expenses	13,312	20,000	6,688	33 4%
2,439,033	**2,383,124**	**(55,909)**	**(2.3%)**	**Total Medical Expenses**	**7,191,624**	**7,210,828**	**19,204**	**0.3%**
291,031	**377,242**	**(86,211)**	**-22.9%**	**Gross Margin**	**904,514**	**912,235**	**(7,721)**	**-0.8%**
				Administrative Expenses				
129,573	137,514	7,941	5 8%	Salaries, wages & employee benefits	410,837	434,441	23,604	5 4%
220	153	(67)	(43 8%)	Professional fees	469	459	(10)	(2 2%)
11,758	18,971	7,213	38 0%	Purchased services	38,268	56,913	18,645	32 8%
6	10,533	10,527	99 9%	Printing and postage	734	31,599	30,865	97 7%
2,092	2,116	24	1 1%	Depreciation & amortization	6,276	6,348	72	1 1%
5,108	4,137	(971)	(23 5%)	Other operating expenses	10,146	12,408	2,262	18 2%
22,581	3,958	(18,623)	(470 5%)	Indirect cost allocation, Occupancy Expense	29,908	11,746	(18,162)	(154 6%)
171,338	**177,382**	**6,044**	**3.4%**	**Total Administrative Expenses**	**496,638**	**553,914**	**57,276**	**10.3%**
				Operating Tax				
15,374	-	15,374	0 0%	Tax Revenue	15,374	-	15,374	0 0%
15,374	-	(15,374)	0 0%	Premium tax expense	15,374	-	(15,374)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
119,693	**199,860**	**(80,167)**	**(40.1%)**	**Change in Net Assets**	**407,876**	**358,321**	**49,555**	**13.8%**
89.3%	***86.3%***	***(3.0%)***	***(3.5%)***	***Medical Loss Ratio***	***88.8%***	***88.8%***	***(0.1%)***	***(0.1%)***
6.3%	***6.4%***	***0.2%***	***2.3%***	***Admin Loss Ratio***	***6.1%***	***6.8%***	***0.7%***	***10.0%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2019

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
48,746	23,101	(25,645)	(111.0%)	Purchase services	147,360	69,303	(78,057)	(112.6%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	493,481	524,175	30,694	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	52,429	47,598	(4,831)	(10.2%)
100,376	140,162	39,786	28.4%	Repair and maintenance	320,794	420,486	99,692	23.7%
50,385	46,432	(3,953)	(8.5%)	Other Operating Expense	185,140	139,296	(45,844)	(32.9%)
(381,478)	(400,286)	(18,808)	(4.7%)	Indirect allocation, Occupancy	(1,199,206)	(1,200,858)	(1,652)	(0.1%)
(1)	**-**	**1**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
1	**-**	**1**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

OTHER INCOME STATEMENTS - SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $253.9 thousand, favorable to budget $336.3 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $119.7 thousand, unfavorable to budget $80.2 thousand

CalOptima
Balance Sheet
September 30, 2019

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$500,678,412	Accounts Payable	$7,116,206
Investments	535,432,042	Medical Claims liability	851,608,110
Capitation receivable	293,984,727	Accrued Payroll Liabilities	12,895,520
Receivables - Other	41,164,739	Deferred Revenue	39,410,686
Prepaid expenses	6,028,459	Deferred Lease Obligations	25,435
		Capitation and Withholds	143,835,203
Total Current Assets	**1,377,288,379**	**Total Current Liabilities**	**1,054,891,161**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	9,064,987		
505 City Parkway West	50,489,717		
	96,641,069		
Less: accumulated depreciation	(48,301,741)		
Capital assets, net	48,339,329	Other (than pensions) post employment benefits liability	25,069,864
Other Assets		Net Pension Liabilities	23,500,744
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,103,461,768**
Cash and Cash Equivalents	2,485,421		
Long-term Investments	561,396,534	Deferred Inflows	
Total Board-designated Assets	563,881,955	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	622,380,868	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,048,008,576**	TNE	108,304,218
		Funds in Excess of TNE	839,926,204
Deferred Outflows		**TOTAL NET POSITION**	948,230,422
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,059,099,025**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,059,099,025**

CalOptima
Board Designated Reserve and TNE Analysis
as of September 30, 2019

Type	Reserve Name	Market Value	Benchmark		Variance		
			Low	High	Mkt - Low		Mkt - High
	Tier 1 - Payden & Rygel	154,563,989					
	Tier 1 - Logan Circle	153,378,677					
	Tier 1 - Wells Capital	153,827,568					
Board-designated Reserve		461,770,233	290,615,171	461,580,623	171,155,062		189,610
TNE Requirement	Tier 2 - Logan Circle	102,111,721	108,304,218	108,304,218	(6,192,496)	*	(6,192,496)
	Consolidated:	**563,881,955**	**398,919,389**	**569,884,841**	**164,962,566**		**(6,002,886)**
	Current reserve level	*1.98*	*1.40*	*2.00*			

*Note: Minimum TNE requirement increased in September due to PY Directed Payments included in medical expense per DHCS instruction.

CalOptima
Statement of Cash Flows
as of September 30, 2019

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	5,602,913	12,687,552
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	532,602	1,665,614
Changes in assets and liabilities:		
Prepaid expenses and other	612,784	(240,718)
Catastrophic reserves		
Capitation receivable	15,515,744	16,792,301
Medical claims liability	112,191,160	99,297,159
Deferred revenue	(23,016,201)	(11,624,078)
Payable to providers	12,803,446	34,932,063
Accounts payable	241,839	(33,662,473)
Other accrued liabilities	229,200	244,467
Net cash provided by/(used in) operating activities	124,713,488	120,091,887
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	132,332,879	38,274,255
Change in Property and Equipment	(199,814)	(3,380,054)
Change in Board designated reserves	304,632	(3,736,547)
Change in Homeless Health reserve	-	1,801,087
Net cash provided by/(used in) investing activities	132,437,696	32,958,741
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	257,151,184	153,050,628
CASH AND CASH EQUIVALENTS, beginning of period	243,527,228	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**500,678,412**	**500,678,412**

BALANCE SHEET - SEPTEMBER MONTH:

ASSETS of $2.1 billion increased $108.1 million from August or 5.5%

- **Operating Cash** increased $257.2 million primarily due to the receipt of $104.3 million in State DP, as well as $38.0 million in WCM capitation payments. The remainder of the increase relates to cash flow timing requirements, as funded by the decrease in investments.
- **Investments** decreased $132.3 million due to cash flow timing requirements for operating cash
- **Capitation Receivables** decreased $18.1 million or 5.8% due to timing of WCM capitation received from the Department of Healthcare Services (DHCS)

LIABILITIES increased $102.4 million from August or 10.2%

- **Medical Claims Liability** increased $112.2 million due to accrual of payable for DP
- **Deferred Revenue** decreased $23.0 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)
- **Capitation and Withholds** increased $12.8 million due to increase to increase in capitation to health networks and shared risk pool

NET ASSETS total $948.2 million

Homeless Health Initiative and Allocated Funds
As of September 30, 2019

		Amount
Program Commitment		**$ 100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	$	11,400,000
Recuperative Care		11,000,000
Clinical Field Team Start-Up & Federally Qualified Health Center (FQHC)		1,600,000
Homeless Response Team (CalOptima)		6,000,000
Homeless Coordination at Hospitals		10,000,000
CalOptima Day & QI Program		1,231,087
FQHC – Expansion		570,000
Funds Allocation Total		**41,801,087**
Program Commitment Balance, available for new initiatives		**$ 58,198,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for September 2019

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Huma Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000. \
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors' Meeting
November 7, 2019

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- CY 2014 Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:

  On February 26, 2019, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected to participate in the CY 2014 Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2014 Medicare Part C risk adjustment data and payments. The collection of medical records and medical director/review approval began in April and was completed in September 2019. The deadline for submission of medical records for the selected enrollees was extended by CMS from August 20 to September 20, 2019. CalOptima is currently awaiting to receive the audit results from CMS.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its compliance program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit began in August and concluded with the completion of the on-site audit on September 26th. The final report and executive summary are expected to be released on November 11, 2019.

2. OneCare Connect

- CY 2018 Performance Measure Validation (PMV):

  On May 21, 2019, CMS provided Medicare-Medicaid Plans (MMPs) with an initial notification of upcoming PMV efforts for the following 2018 measurement year elements:

- MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
- MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

MMPs are required to report various monitoring and performance measures, as outlined in the MMP core and state-specific reporting requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures. Validation activities will focus on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production, and primary source verification. The validation webinar occurred on September 18, 2019. CalOptima is anticipating the preliminary draft audit results from CMS to be issued in December 2019. The final report will be issued in early 2020.

- Federal Evaluation of Cal MediConnect:

On September 20, 2019, CMS' contractor (RTI International) informed CalOptima that it is in the process of conducting a federal evaluation of the Cal MediConnect program with all the health plans in the state of California, as part of the larger national evaluation of Duals Demonstrations. During the month of October, RTI International will be meeting with the MMP health plans to learn about the plan's 2019 successes, challenges, lessons learned and any promising practices that may be emerging. Topic areas that will be covered as part of this evaluation include:

- Overall successes and promising practices
- Beneficiary engagement, enrollment and retention
- Provider network, delegation, quality monitoring updates
- Finance, payment, encounter data updates
- Care coordination including care plan options (CPOs), Long Term Services and Supports (LTSS), and behavioral health updates
- Nursing facility diversions and related activities

CalOptima's evaluation is scheduled for October 28, 2019.

3. Medi-Cal

- 2019 Medi-Cal Audit:

The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 4 - 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019 and consisted of an evaluation of CalOptima's compliance with its contract and regulations 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. On June 25, 2019, the DHCS issued its final audit report to CalOptima, which outlined three (3) findings in the areas of case management and coordination of care, access and availability of care, and quality management. CalOptima submitted a timely Corrective Action Plan (CAP) to the DHCS, and it is currently under review.

2 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which will focus on the accuracy and completeness of calendar year 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

  On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the coming weeks. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

- Department of Managed Health Care (DMHC) Routine Examination:

  On August 8, 2019, the DMHC engaged CalOptima for the tri-annual routine examination. This examination will review CalOptima's fiscal and administrative affairs and will include an examination of CalOptima's financial reports. CalOptima's last routine examination was conducted in 2016. The DMHC conducted its entrance conference with CalOptima on October 21, 2019.

- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examination is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed care plan's internal data and accounting systems. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor. The commencement date of the examination has yet to be established, but CalOptima expects to begin receiving data requests soon.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of October 2019.

3 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	100%	100%	100%	100%
June 2019	100%	100%	100%	100%
July 2019	100%	97%	100%	93%

- For the July 2019 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 98% for a focused audit of sixty (60) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of professional claims.
  - The lower compliance score of 93% for denied claims accuracy for July 2019 was due to two (2) inaccurate claims.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
May 2019	100%	100%	93%	100%	50%
June 2019	100%	100%	95%	100%	100%
July 2019	98%	100%	98%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- For the July 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 99% for a focused audit of forty (40) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of PDRs.

- Medi-Cal Customer Service: Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
April – June 2019	89%	88%	100%

- For the April-June 2019 file review of Medi-Cal inquiries, CalOptima's Customer Service department received a compliance score of 92% for a focused audit of nine (9) inquiry calls selected for review:
  - Based on a focused review of nine (9) inquiries, the lower compliance score of 89% for the misclassified calls was due to one (1) misclassified call within the files selected.
  - Based on a focused review of eight (8) inquiries, the lower compliance score of 88% for the file review was due to one (1) missing call recording.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of member inquiries received by the Customer Service department. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of member inquiries within regulatory requirements.

- Medi-Cal Customer Service: Exempt Grievances

Month	Log Requirements	Universe Accuracy	Classification of Exempt Grievances	Accurate Documentation of Exempt Grievances	Complete Resolution of Exempt Grievances	Resolution Timeliness
April – June 2019	89%	100%	100%	100%	100%	100%

- For the April-June 2019 file review of Medi-Cal exempt grievances, CalOptima's Customer Service department:
  - Received a compliance score of 100% based on the overall universe of exempt grievances.

5 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

  - Based on a focused review of nine (9) exempt grievances, the lower compliance score of 89% was due to a Customer Service Representative's notes not aligning with established policies and procedures.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of exempt grievances. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate universe submissions.

- Medi-Cal Utilization Management: Over-and-Under Utilization Process

- CalOptima's Audit & Oversight (A&O) department performed a quarterly audit on the Utilization Management department to assess DHCS audit readiness and compliance in the area of over-and-under utilization reporting process.

- The audit focused on a review of the department's policies and procedures related to identifying, validating and addressing over-and-under utilization. The review was evaluated based upon CalOptima's policies and procedures, and DHCS and DMHC regulatory requirements, which include, but may not be limited to, review of utilization data, process to assess and evaluate compliance with utilization management requirements, and assessment and evaluation of provider referral and specialist care patterns. The review period was 1/1/19 to 6/30/19.

Month	# of Requirements Reviewed	# of Requirements Met	# of Requirements Partially Met	# Requirements Unmet
January 2019 – June 2019	20	2	4	14

- The A&O department has issued CAPs for all findings, and is working collaboratively with the Utilization Management department to ensure all deficiencies are remediated.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	100%	100%	100%	100%
June 2019	100%	100%	100%	100%
July 2019	100%	100%	100%	100%

➢ For the July 2019 file review of OneCare claims, CalOptima's Claims department received a compliance score of 100% on a focused audit of twenty (20) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of paid and denied claims.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
May 2019	100%	100%	100%
June 2019	Nothing to Report	Nothing to Report	Nothing to Report
July 2019	100%	100%	100%

➢ For the July 2019 file review of OneCare PDRs, CalOptima's Claims department received a compliance score of 100% on a focused audit of three (3) PDRs selected for review and a compliance score of 100% for timeliness based on the overall universe of PDRs.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	100%	100%

  - For the April - June 2019 file review of OneCare Part C inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	100%	100%

  - For the April - June 2019 file review of OneCare Part D inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	100%	100%

  - For the April - June 2019 file review of OneCare oral grievances, CalOptima's Customer Service department received a compliance score of 100% for a focused audit of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	100%	100%	100%	90%
June 2019	100%	100%	100%	90%
July 2019	100%	90%	100%	100%

  - For the July 2019 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 98% for a focused audit of twenty (20) claims selected for review and a compliance score of 99% for timeliness based on the overall universe of professional claims.

  - The lower compliance score of 90% for paid claims accuracy for July 2019 was due to one (1) inaccurate claim.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
May 2019	100%	100%	100%
June 2019	100%	100%	100%
July 2019	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- For the July 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 100% for a focused audit of five (5) PDRs selected for review and a compliance score of 100% for timeliness based on the overall universe of PDRs.

- OneCare Connect Customer Service: Part C Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	100%	100%

- For the April - June 2019 file review of OneCare Connect Part C inquiries, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) inquiry calls selected for review.

- OneCare Connect Customer Service: Part D Inquiries (Call Logs)

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	89%	100%

- For the April – June 2019 file review of OneCare Connect Part D inquiries, CalOptima's Customer Service department received a score of 96% on a focused audit of nine (9) inquiry calls selected for review. The lower compliance score of 89% for the file review was due one (1) missing call recording.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of member inquiries received by the Customer Service department. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of member inquiries within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Connect Customer Service: Oral Grievances

Month	Misclassified Calls	File Review	Universe
April - June 2019	100%	100%	0%

➢ For the April – June 2019 file review of OneCare Connect oral grievances, CalOptima's Customer Service department received a score of 100% on a focused audit of nine (9) oral grievances selected for review and a score of 100% for timeliness based on the overall universe of oral grievances. The lower compliance score of 0% was due to inaccuracies in the universe.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of oral grievances. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate universe submissions.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
May 2019	100%	100%	100%	100%
June 2019	80%	100%	100%	100%
July 2019	100%	100%	100%	100%

➢ For the July 2019 file review of PACE claims, CalOptima's Claims department received a score of 100% for a focused audit of twenty (20) claims selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
May 2019	100%	100%	100%	N/A
June 2019	100%	100%	100%	50%
July 2019	100%	100%	100%	N/A

  - For the July 2019 file review of PACE PDRs, CalOptima's Claims department received a score of 100% for a focused audit of eleven (11) PDRs selected for review.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
May 2019	Nothing to Report	67%
June 2019	100%	100%
July 2019	100%	100%

  - For the July 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 100% for a focused audit of five (5) SDRs selected for review.

- PACE: Alternative Care Setting (ACS) Facility Site Review

Facility	Compliance Score
Acacia Adult Day Services	89%
SeniorServ - Anaheim Adult Day Health Care Center	86%
SeniorServ - Santa Ana Adult Day Health Care Center	80%
South County Adult Day Services	100%
Sultan Adult Day Health Care	86%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Acacia Adult Day Services
  - Based on a focused review of fifty-three (53) elements, Acacia Adult Day Services received a compliance score of 89% due to six (6) noncompliant elements in the following requirements --- Maintenance and Housekeeping, General Safety, Patient Rights, Infection Control Plan, and Dietary Services.

- SeniorServ - Anaheim Adult Day Health Care Center
  - Based on a focused review of fifty-two (52) elements, SeniorServ - Anaheim Adult Day Health Care Center received a compliance score of 86% due to seven (7) noncompliant elements in the following requirements --- Fire Life Safety, Maintenance and Housekeeping, General Safety, and Patient Rights.

- SeniorServ - Santa Ana Adult Day Health Care Center
  - Based on a focused review of fifty-one (51) elements, SeniorServ - Santa Ana Adult Day Health Care Center received a compliance score of 80% due to eleven (11) noncompliant elements in the following requirements --- Fire Life Safety, Maintenance and Housekeeping, General Safety, and Dietary Services.

- South County Adult Day Services
  - Based on a focused review of fifty-seven (57) elements, South County Adult Day Services received a compliance score of 100%.

- Sultan Adult Day Health Care
  - Based on a focused review of fifty-one (51) elements, Sultan Adult Day Health Care received a compliance score of 86% due to seven (7) noncompliant elements in the following requirements --- Fire Life Safety, Maintenance and Housekeeping, General Safety, and Patient Rights.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the facility site reviews. The A&O department continues to work with the facilities to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure compliant sites.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

5. Health Network Monitoring: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
May 2019	62%	87%	81%	76%	78%	91%	91%	64%	86%	87%	80%	87%	92%
June 2019	82%	91%	93%	88%	76%	89%	93%	82%	94%	92%	67%	100%	100%
July 2019	85%	86%	93%	89%	91%	92%	94%	86%	90%	96%	100%	100%	100%

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for clinical decision making (CDM). An aggregate of thirty-five (35) files was deficient out of the aggregate total of forty-three (43) files received from the five (5) health networks. Deficiencies for the lower scores for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to obtain appropriate professional to make decision
  - Failure to cite criteria for decision

- Based on the overall universe of Medi-Cal authorizations for June 2019, CalOptima's health networks received an aggregate compliance score of 97% for timely processing of routine authorization requests and a compliance score of 98% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	99%	88%	99%	88%
June 2019	97%	94%	100%	94%
July 2019	99%	95%	99%	91%

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in June 2019 to 99% in July 2019 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with an aggregate of five (5) files marked deficient for timeliness out of the aggregate total of seventy-two (72) files received for July 2019.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 94% in June 2019 to 91% in July 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by three (3) health networks with an aggregate of eighteen (18) files marked deficient for accuracy out of the aggregate total of seventy-four (74) files received for July 2019.

- Based on the overall universe of Medi-Cal claims for June 2019, CalOptima's health networks received an overall compliance score of 94% for timely processing of claims.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

6. Health Network Monitoring: OneCare

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2019	83%	100%	93%	87%	93%	78%	67%	96%
June 2019	85%	100%	99%	93%	93%	80%	79%	95%
July 2019	93%	100%	95%	96%	96%	100%	73%	94%

- Based on a focused review of select files, three (3) health networks drove the lower score for clinical decision making (CDM). An aggregate of six (6) files was deficient out of the aggregate total of fourteen (14) files received for those three (3) health networks. Deficiencies for the lower scores for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- Based on a focused review of select files, two (2) health networks drove the lower scores for letter language. An aggregate of ten (10) files was deficient out of the aggregate total of fifteen (15) files received from the two (2) health networks. Deficiencies for the lower scores for letter language include the following:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for June 2019, CalOptima's health networks received an overall compliance score of 88% for timely processing of standard Part C authorization requests and 73% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	100%	98%	98%	90%
June 2019	100%	95%	100%	95%
July 2019	99%	93%	99%	82%

  - Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 100% in June 2019 to 99% in July 2019 due to untimely processing of multiple claims. The lower score was driven by one (1) health network due to one (1) file marked deficient for timeliness out of the twenty (20) files received for July 2019.

  - Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 95% in June 2019 to 93% in July 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by one (1) health network with two (2) files marked deficient for paid claims accuracy out of the four (4) files received for July 2019.

  - Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in June 2019 to 99% in July 2019 due to untimely processing of multiple claims. The lower score was driven by one (1) health network due to one (1) file marked deficient for timeliness out of the ten (10) files received for July 2019.

  - Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 95% in June 2019 to 82% in July 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by two (2) health networks with an aggregate of three (3) files marked deficient for paid claims accuracy out of the aggregate total of eleven (11) files received for July 2019.

  - Based on the overall universe of OneCare claims for CalOptima's health networks for June 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
    - 89% for non-contracted clean claims paid or denied within 30 calendar days of receipt
    - 94% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

7. Health Network Monitoring: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
May 2019	71%	75%	82%	70%	87%	83%	83%	82%	82%	83%	70%
June 2019	80%	100%	90%	81%	90%	80%	80%	83%	63%	90%	84%
July 2019	89%	95%	89%	95%	86%	91%	74%	85%	100%	82%	87%

- Based on a focused review of select files, three (3) health networks drove the lower score for clinical decision making (CDM). An aggregate of sixteen (16) files was deficient out of the aggregate total of twenty-five (25) files received from the three (3) health networks. Deficiencies for the lower scores for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to obtain appropriate professional to make decision
  - Failure to cite criteria for decision

- Based on a focused review of select files, five (5) health networks drove the lower scores for letter language. An aggregate of twenty-eight (28) files was deficient out of the total of fifty-two (52) files received from the five (5) health networks. Deficiencies for the lower scores for letter language include the following:
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member primary language
  - Failure to describe why the request did not meet criteria in lay language

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for June 2019, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 99% for timely processing of expedited authorization requests.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2019	100%	99%	99%	88%
June 2019	93%	93%	99%	91%
July 2019	100%	87%	99%	96%

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 93% in June 2019 to 87% in July 2019 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by two (2) health networks with an aggregate of three (3) files marked deficient for paid claim accuracy out of the aggregate total of eleven (11) files received for July 2019.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for June 2019, CalOptima's health networks received the following overall compliance scores:
  - 98% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 99% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 98% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and

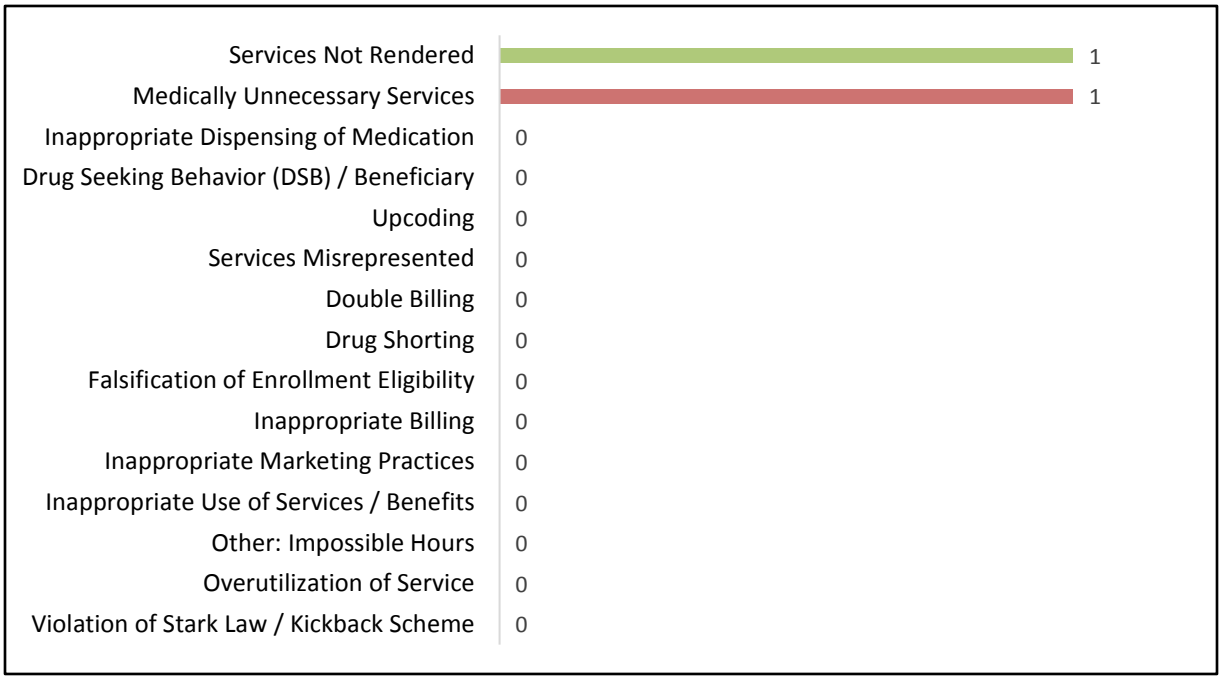
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

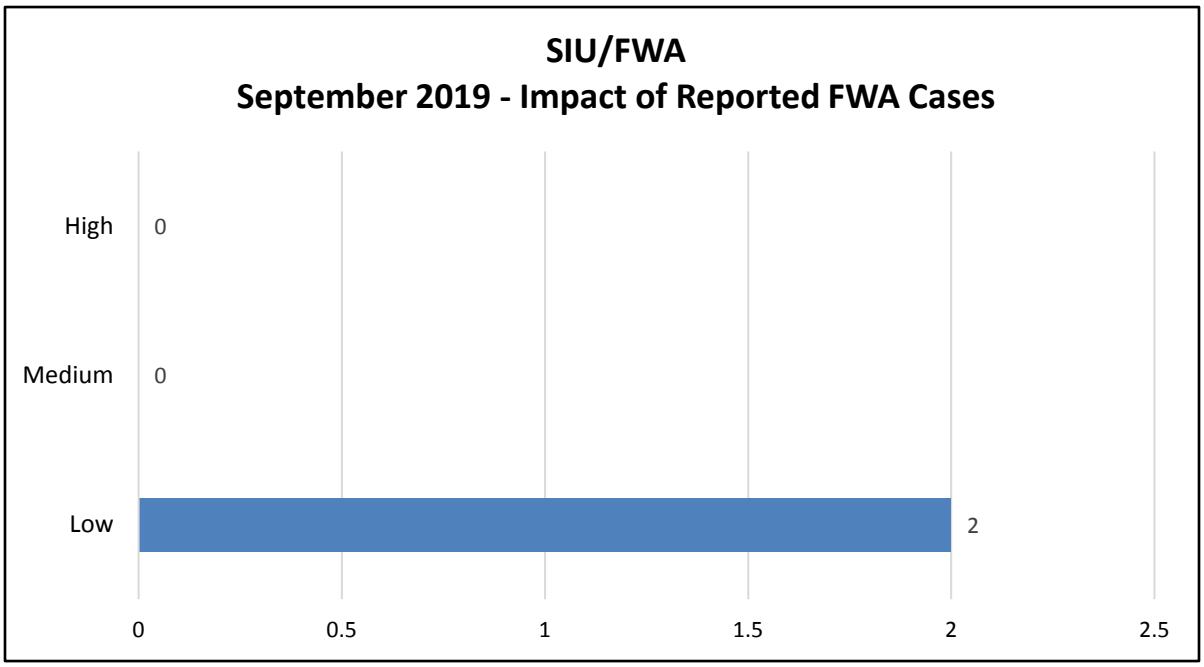
Back to Agenda

policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in September 2019)

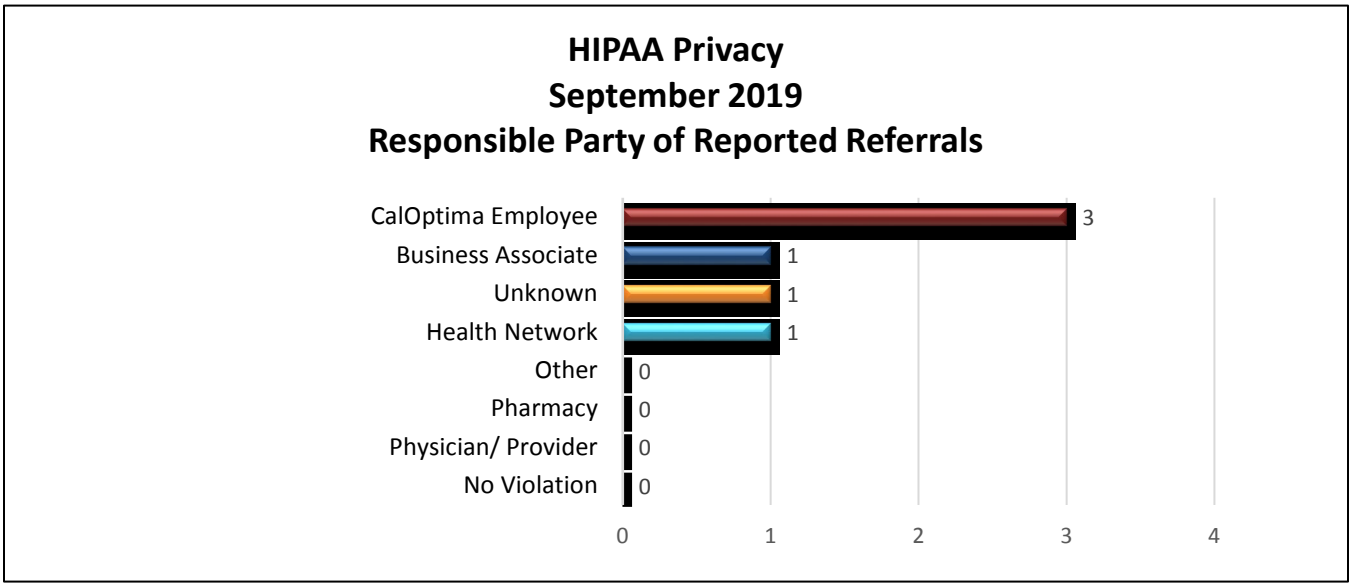


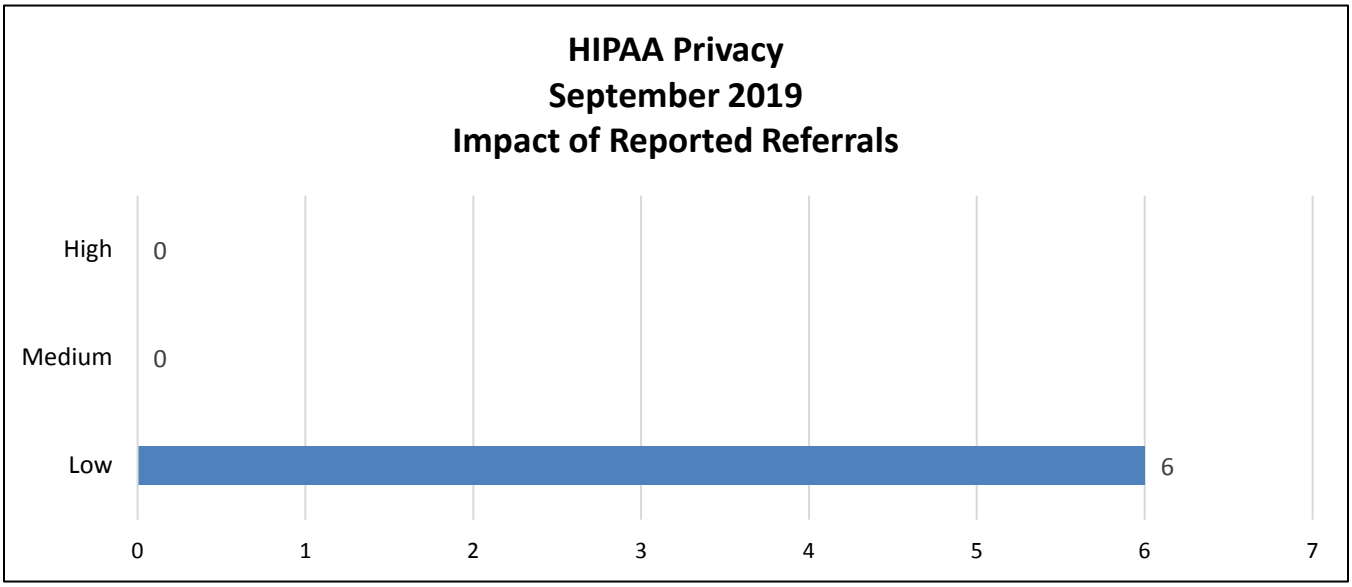


a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

E. Privacy Update (September 2019)





Total Number of Referrals Reported to DHCS (State)	6
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**6**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type. An asterisk (*) indicates that the monitoring results are preliminary and may be subject to change.

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

October 7, 2019

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: October Board of Directors Report

Following a two-week recess, lawmakers will return to Washington on October 15 to face a crowded fall agenda that includes several must-pass items, such as fiscal 2020 spending and a number of expiring health care "extenders." Negotiations also continue around legislation to address drug pricing and surprise medical billing, even as the House impeachment inquiry has heightened tensions between the White House and Congressional Democrats. This report provides an update on activity through October 7.

FY 2020 Budget and Appropriations

The President on September 27 signed a continuing resolution (CR) that extends government funding through November 21. Senate appropriators had hoped to pass the fiscal year (FY) 2020 Labor, Health and Human Services (Labor-HHS) appropriations bill before the end of September, but plans for a mark-up were scrapped amid a partisan dispute over abortion policy and Title X funding. Of note, the Senate Labor-HHS Committee Report included language urging the Centers for Medicare and Medicaid Services (CMS) to clarify strategies that states can implement under current Medicaid authority or waivers to address social determinants of health. The Senate Appropriations Committee managed to mark up 10 of the 12 appropriations bills, and Member-level negotiations resume in mid-October to ready these bills for the Senate floor and conference with the House. Appropriations Committee staff in both chambers have been working to reach agreement on topline spending levels for each of the bills.

Notably, the CR also funds a number of expiring health programs and provisions through November 21, including: community health centers; the National Health Service Corps; the Teaching Health Center Graduate Medical Education Program; the Medicare Special Diabetes Program; the Certified Community Behavioral Health Clinic Demonstration. The CR also delays the scheduled Medicaid Disproportionate Share Hospital (DSH) payment cuts until November 21.

Back to Agenda

Drug Pricing Legislation

House Speaker Nancy Pelosi (D-CA) released her long-awaited prescription drug pricing plan on September 19, the "Lower Drug Costs Now Act" (H.R. 3). The centerpiece of the proposal is the establishment of a "Fair Price Negotiation Program" that would require the Secretary of Health and Human Services (HHS) to negotiate prices for at least 25 drugs annually that are among the 250 most costly single-source drugs in Medicare and the U.S. health system in general. Insulin products would also be included in the negotiation program. HHS would negotiate directly with drug manufacturers to establish a "maximum fair price" that is no more than 120 percent of the "Average International Market" (AIM) price, the volume-weighted average of the price in six countries: Australia, Canada, France, Germany, Japan and the United Kingdom. For certain drugs with no international price available, the bill stipulates that the maximum fair price shall not exceed 85 percent of the average manufacturer price. Once selected for inclusion, a drug would remain in the negotiation program at least until a generic or biosimilar competitor comes to market.

The maximum fair price would be applied to Medicare; manufacturers would also be required to offer that price to group and individual health plans in the commercial market. Given the existing Medicaid "best price" law, the maximum fair price would also be applicable to Medicaid programs. Manufacturers who overcharge Medicare or fail to offer the negotiated price to other payers would be subject to a steep civil monetary penalty. If a manufacturer refuses to negotiate with HHS, the company will be assessed an escalating excise tax on annual gross sales of the product, starting at 65 percent and increasing by 10 percent each quarter of noncompliance, up to a maximum of 95 percent.

The "Lower Drug Costs Now Act" also includes several proposals similar to those found in the Senate Finance Committee-passed "Prescription Drug Pricing Reduction Act" (S. 2543). Both measures include inflationary rebates in Medicare Parts B and D, which would require manufacturers to lower their prices or pay a rebate to the government if they have increased the price of a drug above inflation. The bills also establish a cap on out-of-pocket costs for Part D beneficiaries, set at $2,000 in H.R. 3 and $3,100 in S. 2543. Notably, H.R. 3 would exclude drugs selected for price negotiation from being considered as covered outpatient drugs under the 340B Drug Pricing Program.

The House Ways and Means, Energy and Commerce, and Education and Labor Committees plan to mark up H.R. 3 promptly, with a House floor vote target of late October. Meanwhile, Senate Finance Committee Chairman Chuck Grassley (R-IA) has been pressing his fellow Republicans to support S. 2543, which has the President's support. However, many in the GOP remain opposed to the inflationary price caps included in the Senate bill, which was passed by the

Back to Agenda

Finance Committee with a majority of Republicans on the panel voting against it. Further revisions will be necessary to garner Senate GOP support including modifying the Medicare Parts B and D inflationary rebates and refining manufacturer disclosure requirements. Senate Democrats will also insist on floor votes on controversial issues such as repealing the Medicare Part D non-interference clause, further complicating the path forward.

In short, it will be difficult to wrap up a year-end deal on drug pricing with bipartisan and bicameral support. As Chairman Grassley has acknowledged, negotiations around prescription drug pricing could carry into 2020.

Surprise Billing

While the momentum around surprise billing has slowed somewhat amid the busy fall agenda, Committee leaders are still hoping to advance legislation to address the issue before year-end. House Ways and Means Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) are discussing a "negotiated rulemaking" proposal, under which the Departments of HHS, Labor, and Treasury would use the federal rulemaking process to set appropriate payment rates and determine the proper use of arbitration for out-of-network billing situations. This approach raises questions about the ability of the legislation to generate savings, however. Ultimately, the House is expected to advance legislation that more closely resembles the benchmark payment rate approach adopted in the "No Surprises Act" (H.R. 3630) previously passed by the Energy and Commerce Committee.

Meanwhile, some Members on the House Education and Labor Committee are asking Committee Leadership to take up a solution floated by Reps. Raul Ruiz (D-CA) and Phil Roe (R-TN), whose bill relies on "baseball-style" arbitration to determine reimbursement and rejects altogether the benchmark payment rate approach found in H.R. 3630 and the Senate Health, Education, Labor and Pensions (HELP) Committee-passed "Lower Health Care Costs Act" (S. 1895). The leaders of the Energy and Commerce Committee and HELP Committee are continuing to discuss areas of agreement between the Committees' approaches. Given the significant potential cost savings generated from surprise billing legislation – estimated at $21.9 billion over 10 years for the Energy and Commerce Committee proposal and $24.9 billion for the HELP Committee proposal – and the need to extend expiring health provisions, surprise billing legislation is likely to become a higher priority as the end of the year approaches.

Medicare Executive Order

The President on October 3 signed an Executive Order (EO) on "Protecting and Improving Medicare for our Nation's Seniors." While the scope of the EO is limited to the Medicare

Back to Agenda

program, it does provide a glimpse into the Administration's broader thinking on the privatization of federal health care, including directing fee-for-service government programs to adopt more payment approaches (and pricing) utilized by managed care organizations. Among other proposals, the EO aims to: expand Medicare Advantage (MA) plan options and flexibility, including changes to increase access to Medical Savings Accounts and promote telehealth; ensure that traditional fee-for-service Medicare is not advantaged over MA; direct HHS to issue rulemaking around network adequacy for MA plans; reduce regulatory burden to enable providers to spend more time with patients; reduce disparities in reimbursement between physicians and non-physician practitioners; minimize the time between FDA approval and coverage decisions by CMS; and encourage competition through site neutral policies.

Grassley Statements on Medicaid

On October 2, Senate Finance Committee Chairman Chuck Grassley (R-IA) sent a letter to CMS seeking information on Medicaid payments being made on behalf of deceased beneficiaries. The letter cited recent reports from the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG) that suggest that multiple state Medicaid agencies have made payments to managed care organizations for deceased individuals. A 2019 OIG report, for example, estimated that California made unallowable Medicaid payments to deceased individuals totaling $70.9 million between July 2014 and December 2017. Sen. Grassley's letter calls on CMS to implement reforms to prevent such improper payments.

On September 21, Sen. Grassley published an opinion piece in Modern Healthcare calling for an end to spread-pricing in Medicaid, along with other changes to improve transparency around drug reimbursement in the program. According to Sen. Grassley, the current pricing structure allows pharmacy benefit managers (PBMs) to reap "excessive reimbursements" on generic drugs.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

CalOptima
Legislative Report
By Don Gilbert and Trent Smith
October 16, 2019

Governor Newsom brought the 2019 Legislative Session to end this past Sunday when he took final action on the 1,042 bills that reached his desk, signing 870 bills into law. Governor Newsom vetoed 16.51percent of bills he reviewed, a similar rate to Governor Brown's in his last year in office. Many of those vetoes came in the final hours before the deadline for the Governor to sign or veto bills. The Legislature can override any of the Governor's vetoes with a two-thirds vote. However, 1980 was the last time the Legislature took such action.

Below is a summary of the bills we followed for CalOptima and their final status:

AB 115 – Assembly Budget Committee
State lawmakers sent Governor Newsom a budget trailer bill to tax state-contracted managed care organizations (MCO), the revenue from which would be matched with federal dollars and returned to the state to offset Medi-Cal costs. The MCO tax is expected to generate $6.9 billion over the next three and a half years.

The existing MOC tax expired July 1. The federal government, which regulates health-related taxes that draw down federal Medicaid funds, is required to approve renewal of the tax. However, AB 115 was drafted to meet all federal requirements, meaning federal approval is expected. The Department of Health Care Services (DHCS) recently submitted its application to the federal government.

Governor Newsom signed AB 115 into law.

AB 744 - Aguiar-Curry
This measure requires health plans to reimburse providers for the diagnosis, consultation, or treatment of an enrollee delivered through telehealth services on the same basis and rates as an in-person diagnosis, consultation, or treatment. CAHP and the California Chamber of Commerce opposed AB 744 on the bases that the bill created a new mandate that would increase the cost of healthcare. Despite the opposition, AB 744 passed the Assembly 79-0. The author, who represents a rural district in Northern California, successfully argued that telehealth enhances access to care, thereby keeping people healthy and preventing more costly health care services.

Governor Newsom signed AB 744 into law.

October 16, 2019

AB 1494 - Aguiar-Curry
AB 1494 makes the use of telehealth easier in the time of natural disasters. The bill would require that telehealth services, telephonic services, and other specified services be reimbursable when provided by health clinics or similar facilities immediately following a state of emergency. The bill requires DHCS to obtain federal approval and federal matching funds.

AB 1494 was signed into law by the Governor.

AB 218 – Chu
Assemblyman Chu's bill, commencing January 1, 2020, requires field testing of all Medi-Cal beneficiary informational materials that are translated into threshold languages. "Field testing" is defined as a review of translations for accuracy, cultural appropriateness, and readability. Managed care plans, like GCHP, must have their materials field tested under this program.

AB 218 would also require the department to consult with stakeholders to identify at least ten documents that are released to Medi-Cal beneficiaries so that a readability expert and stakeholders may review and revise those documents. The bill requires the readability expert and the stakeholders to provide the department with specific recommendations for revising the selected documents to improve the readability of the documents. AB 218 requires the department to rerelease the documents with revisions based on those recommendations and requires the translation and field testing of those documents. Implementation of AB 218 is required no later than January 1, 2021.

Governor Newsom signed AB 218 into law.

AB 166 – Gabriel
This bill requires DHCS to establish, no later than January 1, 2021, a violence intervention pilot program in nine specified counties, including. DHCS is required to consult with identified stakeholders, such as professionals in the community violence intervention field, for purposes of establishing the pilot programs. AB 166 requires DHCS to provide violence prevention services that are rendered by a qualified violence prevention professional to a Medi-Cal beneficiary who meets identified criteria, including that the beneficiary has received medical treatment for a violent injury.

Governor Newsom vetoed AB 166. In his veto message the Governor sited the 2019 Budget Act, which provided $30 million in the General Fund for the California Violence Intervention and Prevention (CalVIP) Program, the largest investment in the program's history. He also highlighted that he signed AB 1603 (Wicks) which codifies the CalVIP

Back to Agenda

program in statute and increases the grant amount that can be distributed. Hospital-based violence intervention programs are eligible for grant funding through CalVIP.

The Governor concluded his veto message by applauding the Legislature's intent to secure additional funding for violence intervention programs, he encouraged them to pursue these efforts as part of the annual budget process where a comprehensive conversation about spending priorities for the Medi-Cal program can take place.

AB 848 - Gray
Assemblyman Gray's bill adds continuous glucose monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary, subject to utilization controls. The bill also authorizes DHCS to require manufacturers of a continuous glucose monitors to enter into rebate agreements with the department.

Governor Newsom vetoed AB 848. In his veto message he again voiced support for the policy of the proposal but pointed to the budget process as the better avenue to pursue such proposals.

AB 1088 – Wood
AB 1088 requires DHCS to seek a federal waiver to implement an income disregard, allowing an aged, blind, or disabled individual who becomes ineligible for Medi-Cal benefits because of the state's payment of the individual's Medicare Part B premiums, to remain eligible for the Medi-Cal program if their income and resources otherwise meet all eligibility requirements. The bill authorizes DHCS to implement this policy by provider bulletins or similar instructions until regulations are adopted. DHCS is required to provide the Legislature with a status report by July 1, 2021, and on a semiannual basis, until regulations have been adopted.

Governor Newsom signed AB 1088 into law.

AB 1642 – Wood
Assemblyman Wood authored AB 1642 in response to a report criticizing the timely access to care provided in many parts of rural California. AB 1642 mandate new reporting requirements on Medi-Cal managed care plans outlining to DHCS how the plans arrange for the delivery of services, such as transportation services, to enrollees. The bill requires the department to evaluate, as part of its review and approval of an alternative access standard, if the resulting time and distance is reasonable to expect a beneficiary to travel to receive care. AB 1642 further requires a Medi-Cal managed care plan that has received approval from the department to utilize an alternative access

Back to Agenda

standard to provide their enrollees with transportation services if the enrollee must travel to a medical appointment further than established access standards allow.

AB 1642 was signed by Governor Newsom.

As reported last month, DHCS Director, Jennifer Kent, has resigned. Richard Figueroa, who has a long history working in various health related roles in Sacramento, is currently serving as the interim director at DHCS. There is no stated timeline on when a permanent director will be selected.

Back to Agenda

2019–20 Legislative Tracking Matrix

BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 3877	**Bipartisan Budget Act of 2019:** Will enact a two-year framework for the federal budget (through fiscal year 2021). This bill gives a broad blueprint for federal spending and prevents the implementation of automatic spending cuts – also known as sequestration – that are triggered, generally, when Congress misses budget deadlines. Of note, the passing of the Bipartisan Budget Act of 2019 removed proposed spending cuts to Medicaid.	**08/02/2019** Signed into law	CalOptima: Watch
AB 74	**FY 2019-20 California State Budget:** Will enact a $214.8 billion spending plan for FY 2019-20, with General Fund (GF) spending at $147.8 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Updates on the Pharmacy Services carve-out ■ Revisions to the expansion of Medi-Cal ■ Proposition 56 supplemental payment funding ■ Funding to respond to the homelessness crisis	**06/30/2019** Signed into law	CalOptima: Watch
AB 101	**Housing Development and Financing Budget:** Will enact housing trailer bills in the California 2019-2020 budget. Housing Development and Financing budget trailer bills include policy changes related to the housing and homeless services budget, including: ■ $650 million in grant funding for homeless services ■ Bypassing certain California Environmental Quality Act (CEQA) regulations to expedite the establishment of homeless shelters	**07/31/2019** Signed into law	CalOptima: Watch
AB 115	**Managed Care Organization (MCO) Tax Renewal:** Proposes a renewal of, until 12/31/2022, and new structure for the MCO tax, which would be effective retroactive to 7/1/2019.	**09/26/2019** Signed into law **09/12/2019** Passed Senate floor **09/12/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
SB 78	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Prop 56 Value Based Payment (VBP) Behavioral Health integration program ■ Optional benefit restoration (optician and optical services, audiology, speech therapy, podiatry, and incontinence creams) ■ Health Homes Program (HHP) funding extension until 7/1/2024 ■ State-based Individual Mandate ■ Managed Care Organization (MCO) Tax renewal intent language	**06/27/2019** Signed into law	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 104	**Health Budget:** Will enact health care trailer bills in the California 2019-2020 budget. ■ Expansion of full-scope Medi-Cal ages 19-25 regardless of immigration status ■ Eligibility expansion for low-income seniors (122% FPL to 138% FPL) ■ Extension of maternal-mental health Medi-Cal coverage ■ Implementation of a PACE rate adjustment	**07/09/2019** Signed into law	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 577 Eggman	**Maternal Mental Health Care Services:** Extends eligibility for an individual to receive maternal mental health care services through the Medi-Cal Access Program for women below 213% federal poverty level from 60 days post-pregnancy to 12 months post-pregnancy or the diagnosis of a maternal mental health condition. Medi-Cal postpartum care services are covered for any individual who was pregnant and experienced child birth, delivery or miscarriage. Of note, the extension of maternal mental health services was included in the Governor's May Revision budget and signed into law with the passing of SB 104.	**10/12/2019** Signed into law **09/03/2019** Passed Senate floor **05/24/2019** Passed Assembly floor **02/14/2019** Introduced	CalOptima: Watch
AB 1175 Wood	**Medi-Cal Mental Health Services Data Sharing:** Would have required the monthly exchange of member data between a County Specialty Mental Health Plan (MHP) and a Medi-Cal Managed Care Plan (MCP) for any member that has received or is receiving specialty mental health services. The use of a data exchange system was to be mutually agreed upon between the MHP and MCP. Data collected was to be used to improve care coordination for those with mild, moderate or severe mental health needs. Any disputes regarding covered mental health services between the MHP and MCP would have been required to be resolved by the Department of Health Care Services within 30 calendar days.	**10/13/2019** Vetoed **09/04/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch
SB 10 Beall	**Mental Health Support Services Certificate:** Would have created the Certified Support Specialist (CSS) certificate program, which would have allowed parents, peers, and family to become a CSS. A CSS would have been able to provide non-medical mental health and substance abuse support services. Additionally, SB 10 would have required the Department of Health Care Services (DHCS) to include CSS as a provider type, covered by Medi-Cal. The certificate program would have been funded through Mental Health Services Act funds and, if federally approved, the peer-support program would have been funded through Medi-Cal reimbursement.	**10/13/2019** Vetoed **09/05/2019** Passed Assembly floor **05/21/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 163 Portantino	**Autism Spectrum Disorder (ASD) Treatment:** Would have revised and expanded the definitions of those providing care and support to individuals with Autism Spectrum Disorder (ASD) and redefined the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental Individual-differences, and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, would have been authorized to be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services would not have been denied or limited if a parent or caregiver is unable to participate.	**10/12/2019** Vetoed **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate floor **01/24/2019** Introduced	CalOptima: Watch CAHP: Oppose AHIP: Oppose

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 678 Flora	**Podiatric Services as a Medi-Cal Covered Benefit:** Modifies authorizations of services so that a podiatrist would no longer be required to submit prior authorization for services during the patient's visit if a physician and surgeon providing the same services would not be required to submit prior authorization. Additionally, removes the limit on how many visits the patient can make to a podiatrist. Permits a podiatrist to bill Medi-Cal the same rate that a physician or surgeon would bill for the same services.	**10/02/2019** Signed into law **08/15/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/15/2019** Introduced	CalOptima: Watch
AB 781 Maienschein	**Pediatric Day Health Care (PDHC) Services:** Expands PDHC service hours to any day of the week and at any time of the day, so long the number of respite hours allocated are available. Would allow no more than 23 hours per calendar day of covered services. Currently, a parent or guardian may seek PDHC services up to 30 calendar days each year and for no more than 24 hours at a time. PDHC services are required to be provided by a facility licensed through the Department of Public Health and include both physical and social services. The PDHC benefit is not included in the scope of covered services provided by Medi-Cal managed care plans and is a benefit provided through fee-for-service Medi-Cal.	**07/09/2019** Signed into law **06/27/2019** Passed Senate floor **06/17/2019** Passed Assembly floor **02/19/2019** Introduced	CalOptima: Watch
AB 848 Gray	**Continuous Medi-Cal Coverage for Glucose Monitors:** Would have included glucose monitors as a Medi-Cal covered benefit, to be funded through state reimbursement rates. Cost of the glucose monitoring devices is unknown at this time. The Department of Health Care Services estimated this benefit would have cost $100.8 million total funds ($31.9 million General Fund (GF), $68.9 million Federal Fund (FF)) the first year and $92.7 million total funds ($29.4 million GF, $63.3 million FF) the second year.	**10/13/2019** Vetoed **09/04/2019** Passed Senate floor **05/22/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch

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

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1004 McCarty	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Developmental Screening Services:** Requires developmental screenings services as part of the EPSDT program for children 0-3 years of age. Recommends developmental screenings take place for children at the age of 9 months, 18 months, and 30 months. All screenings are to be in compliance with developmental screening guidelines set in place by the American Academy of Pediatrics. AB 1004 allows DHCS to adjust capitation rates for providers, with the use of value-based purchasing, as an incentive to improve EPSDT outcomes.	**09/30/2019** Signed into law **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1839 Ruiz	**Medicaid Services Investment and Accountability Act of 2019:** Extends spousal impoverishment protections when a spouse is receiving skilled nursing care, provides states the ability to provide coordinated care for children with special needs through the use of health home services, and would require drug manufacturers to disclose drug product information and pay a fine for the misclassification of prescribed medications.	**04/18/2019** Signed into law **04/02/2019** Passed the Senate **03/25/2019** Passed the House **03/21/2019** Introduced	CalOptima: Watch
AB 1088 Wood	**Medi-Cal Eligibility without a Share-of-Cost:** Effective July 1, 2021 through the use of a State Plan Amendment or Waiver, eliminates the "Share of Cost (SOC)" and maintains eligibility for Medi-Cal, for individuals who are aged, blind, or disabled, once the Department of Health Care Services (DHCS) begins to pay for the individual's Medicare Part B premium. Currently, individuals in this eligibility category with income levels above 100 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as SOC. Under SOC, beneficiaries must take full responsibility for health care expenses up to a predetermined amount for the month in which they receive services or risk losing Medi-Cal eligibility. This bill ensures that individuals have access to Medi-Cal without incurring extra financial burdens.	**10/02/2019** Signed into law **09/05/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
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.	**09/13/2019** Held in Assembly **08/30/2019** Passed Assembly Committee on Appropriations **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**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. 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.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 923 Feinstein	**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. 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.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
AB 143 Quirk-Silva	**Homeless Shelter Crisis:** Extends existing law, AB 932 (2017), until January 1, 2023, allowing designated cities or counties to establish a shelter crisis that exempts the construction of a homeless shelter from the California Environmental Quality Act (CEQA). Adds to the list of designated municipalities the County of Alameda, the County of Orange, and the City of San Jose. Requires transition plans for permanent housing for participants within the operational plans of each shelter. Additionally, this exemption only applies to the construction of a homeless shelter owned by either a state agency, city, county, or government-owned land.	**09/26/2019** Signed into law **09/05/2019** Passed Senate floor **05/09/2019** Passed Assembly floor **12/13/2018** Introduced	CalOptima: Watch County of Orange: Support
AB 1199 Petrie-Norris	**Use of Fairview Developmental Center:** Requires a public hearing and public comments regarding the use of the Fairview Developmental Center in Costa Mesa, CA.	**10/12/2019** Signed into law **09/05/2019** Passed Senate floor **05/16/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch
SB 450 Umberg	**Motel Conversion for Supportive and Transitional Housing:** Exempts developers from following California Environmental Quality Act (CEQA) steps in order to expedite the development of motel rooms into supportive and transitional housing units.	**09/26/2019** Signed into law **09/09/2019** Passed Assembly floor **05/06/2019** Passed the Senate **02/21/2019** Introduced	CalOptima: Watch County of Orange: Support

MEDI-CAL MANAGED CARE PLAN OVERSIGHT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1642 Wood	**Medi-Cal Managed Care Plans:** Requires Medi-Cal managed care plans (MCPs) to provide assistance with transportation services for long-distance medical appointments and scheduling for out-of-network providers that may be necessary due to network adequacy deficiencies. Broadens and clarifies the authority of the Department of Health Care Services (DHCS) to levy sanctions on both MCPs and Mental Health Plans.	**10/02/2019** Signed into law **09/04/2019** Passed Senate floor **05/29/2019** Passed Assembly floor **02/22/2019** Introduced	CalOptima: Watch
SB 503 Pan	**Subcontracts:** Would have required Medi-Cal managed care plans (MCPs) to conduct annual audits, with at least 10 percent being conducted as surprise audits, of subcontractors who perform delegated functions involving medical review and decision making. Would have required the Department of Health Care Services (DHCS) to establish an audit tool to be used by the MCP, beginning January 1, 2021. Audits of subcontractors would have begun no sooner than January 1, 2022 and would have required audit results to be reported to DHCS, including the identification of the subcontractor being audited. Additionally, if more than one MCP subcontract with the same subcontracted provider, those MCPs would have been able to conduct a joint audit.	**10/13/2019** Vetoed **09/09/2019** Passed Assembly floor **05/22/2019** Passed Senate **02/21/2019** Introduced	CalOptima: Watch

MEMBER MATERIALS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 318 Chu	**Materials for Medi-Cal Members:** Would have required Medi-Cal managed care plans' (MCPs) specific written health education and information materials to be reviewed through "field testing" to ensure all materials meet readability and suitability standards. Materials required for field testing were to include: "Enrollment and disenrollment forms and information, new member welcome packets, member handbooks, appointment notices and reminders, forms and information regarding grievance or complaint procedures and information regarding external review of plan decisions, and notices of action." Field testing could have been conducted internally by the MCP or by an external entity, but must be done by a native speaker of the language being reviewed. The findings of the field testing were to be reported to the Department of Health Care Services (DHCS). Additionally, would have required DHCS to establish a workgroup of advocates and MCPs to measure the readability of member-facing materials used by MCPs, such as the *Rights and Responsibilities Form and the Medi-Cal Request for Information Form.*	**10/13/2019** Vetoed **09/05/2019** Passed Senate floor **05/23/2019** Passed Assembly floor **01/30/2019** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
ACR 131 Petrie-Norris	**Programs of All-Inclusive Care for the Elderly (PACE) Month:** Assembly Concurrent Resolution that recognizes September 2019 as PACE Month in California.	**09/09/2019** Resolution adopted in the Senate **08/30/2019** Resolution adopted in the Assembly **08/19/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor
AB 1128 Petrie-Norris	**Programs of All-Inclusive Care (PACE) Licensing:** Exempts a primary a care clinic, adult day health care center, or home health agency from the Department of Public Health (DPH) licensing requirements. Applies to agencies solely serving PACE participants, effective upon agreement of the Department of Health Care Services (DHCS), but no later than January 1, 2021. This will streamline the licensing process by having the clinic licensing, adult day services licensing, or home health licensing under the responsibility of DHCS. Additionally, authorizes a primary care clinic, adult day health care center, or home health agency to provide services to a Medi-Cal beneficiary during the PACE enrollment eligibility period, for no more than 60 days, when that center solely serves PACE participants.	**10/12/2019** Signed into law **09/10/2019** Passed Senate floor **05/28/2019** Passed Assembly floor **02/21/2019** Introduced	CalOptima: Watch CalPACE: Support; Sponsor

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.	**09/13/2019** Moved to inactive file; Two-year bill at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Support; Cosponsor

*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: October 14, 2019

2019 Federal Legislative Dates

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

2019 State Legislative Dates

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

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

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).

Board of Directors Meeting
November 7, 2019

CalOptima Community Outreach Summary — October 2019

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

In September, Community Relations celebrated the Mid-Autumn Festival with Orange County Asian communities by sponsoring and hosting a resource table at three community events. The Mid-Autumn Moon Festival also known as "Children's Day" is celebrated in the Chinese and Vietnamese cultures, which is approximately 14 percent of CalOptima's membership. The festival celebrates the gathering of family and friends, giving thanks for the harvest, harmonious union and praying for longevity and good fortune.

On September 7, 2019, the Mid-Autumn Children's Festival was hosted by the Vietnamese American Youth Organizations at the Atlantis Play Center in Garden Grove. More than 30 vendors were in attendance to provide resources and festive activities for the children. More than 3,500 participants gathered to enjoy cultural performances and traditional games. Lanterns were provided to children to participate in a lantern parade before the closing of the event.

On September 14, 2019, the Mid-Autumn Moon Festival was hosted by the Vietnamese Cultural Center and the Office of Supervisor Do at Mile Square Park in Fountain Valley. More than 1,500 participants gathered for music and traditional performances. Lanterns and moon cakes were distributed to children and families participating in the event.

Back to Agenda

On September 21, 2019, the Moon Festival was hosted by the Asian American Senior Citizens Service Center at their location in Santa Ana. Approximately 80 Chinese American seniors gathered for traditional Chinese music and performances. The seniors shared memories and enjoyed lunch and traditional moon cakes.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During October 2019, CalOptima participated in 61 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
10/01/19	• Collaborative to Assist Motel Families Meeting
10/02/19	• Anaheim Human Services Network • Orange County Healthy Aging Initiative • Orange County Veterans and Military Families Collaborative
10/03/19	• Continuum of Care Homeless Provider Forum
10/04/19	• Covered Orange County General Meeting • Help Me Grow Advisory Meeting • Together4Teens Conference Advisory Meeting
10/07/19	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting • Orange County Strategic Plan for Aging Health Care Committee Meeting
10/08/19	• Orange County Strategic Plan for Aging Social Engagement Committee Meeting • Orange County Cancer Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
10/09/19	• Buena Park Collaborative Meeting • Orange County Communications Workgroup • Anaheim Homeless Collaborative Meeting • Orange County Strategic Plan for Aging Health Care Subcommittee Meeting • Healthcare Task Force Meeting • Orange County Communication Workgroup
10/10/19	• Buena Park Collaborative • Orange County Aging Services Collaborative General Meeting • Kid Healthy Community Advisory Committee Meeting • Garden Grove Collaborative Leadership Luncheon Meeting
10/11/19	• Senior Citizens Advisory Council Meeting

Back to Agenda

10/14/19	• Fullerton Collaborative Meeting
10/15/19	• Placentia Community Collaborative Meeting • Orange County Cancer Coalition Meeting
10/16/19	• Orange County Promotoras • Minnie Street Family Resource Center Professionals Roundtable • La Habra Community Collaborative Meeting • Covered California Steering Committee Meeting • Disability Coalition of Orange County Meeting • 4th Annual C.a.F.e — Community and Faith Engagement • Orange County Communication Workgroup
10/17/19	• Orange County Children's Partnership Committee Meeting • Surf City Senior Provider Networking Luncheon Meeting • Vendor Fair hosted by UC Irvine Health
10/18/19	• Santa Ana Early Learning Initiative
10/22/19	• Orange County Senior Roundtable Meeting
10/24/19	• Orange County Care Coordination for Kids • Asian Pacific Islander Leadership Forum
10/28/19	• Stanton Collaborative Meeting • Community Health Research Exchange Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
10/01/19	2	• Annual International Older Adult Fair hosted by City of Santa Ana Senior Center
10/04/19	1	• Senior Wellness Fair hosted by City of Orange Senior Center
10/05/19	3	• Annual Walk-a-thon, Health and Resource Fair hosted by Madison Park Neighborhood Associations (Sponsorship Fee: $1,000 included agony's logo on t-shirts, posters and flyers, special recognition by city of Santa Ana during event, one resource table for outreach and opportunity to provide few remarks at the event.)
	2	• 5th Annual Veterans Resource Fair hosted by Office of Assemblyman William P. Brough
	2	• 35th Arirang Festival of Orange County hosted by Arirang Festival of Orange County

Back to Agenda

10/07/19	1	• Health Fair at St. John's Manor hosted by Covia
10/11/19	2	• Health Fair and Flu Clinic hosted by City of Brea Senior Center (Registration Fee: $120 included two tables for outreach at the event,)
10/12/19	2	• Health and Wellness Fair hosted by Nhan Hoa Comprehensive Clinic
	2	• Somang Society Conference 2019 hosted by Somang Society (Sponsorship Fee: $1,500 included an exhibitor space and 1/2 page ad in event program.)
	3	• Together4Teens Conference hosted by Wellness Prevention Coalition (Sponsorship Fee: $1,000 included agency mention in press release, e-newsletter, social media, agency's logo on all promotional items, two reserved seats for keynote speaker portion, one table for outreach at the event, and 1/2 page ad in event program.)
10/19/19	1	• Senior Health and Resource Fair hosted by the City of Newport Beach Oasis Senior Center
	3	• Health and Resource Fair hosted by Irvine Evergreen Chinese Senior Association
10/23/19	1	• Medicare Info Fair hosted by the City of Cypress Senior Center (Registration Fee: $50 included one table for outreach at the event.)
	1	• Annual Community Resource and Health Fair hosted by Garden Grove Unified School District
10/24/19	2	• Senior Scam Stopper hosted by the Office of Assemblywoman Cottie Petrie-Norris
	2	• Dia de los Muertos hosted by Buena Clinton Youth and Family Center (Sponsorship Fee: $1,000 one exhibitor space with signage during the event, speaking opportunity, photo on the stage and recognition of sponsorship with a plaque.)
10/25/19	2	• 30th Annual Southern California Alzheimer's Disease Research Conference hosted by UCI MIND (Registration Fee: $250 included one table for outreach and general admission for two representatives.)
10/27/19	3	• OC Free Health Fair hosted by the Vietnamese Physician Association of Southern California Foundation (Sponsorship Fee: $5,000 included agency's name on event fliers, recognition on television/radio/newspapers, email blast, website and social media, one banner display at the event, brochure placed in attendee bag and two tables at the event for outreach.)

Back to Agenda

CalOptima organized or convened the following eleven community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
10/01/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
10/03/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center — Topic: Shape Your Life (English and Spanish)
10/04/19	• County Community Service Center Health Seminar — Topic: Mindfulness Based Stress Reduction Overview (Vietnamese)
10/08/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
10/10/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center — Topic: Shape Your Life (English and Spanish)
10/11/19	• OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Retention and Sales Event at Anaheim Downtown Community Center
10/15/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)
10/17/19	• CalOptima Health Education Workshop at Ponderosa Park Family Resource Center — Topic: Shape Your Life (English and Spanish) • County Community Service Center Health Seminar — Topic: OneCare Connect (Vietnamese)
10/18/19	• County Community Service Center Health Seminar — Topic: Mindfulness Based Stress Reduction (Vietnamese)
10/22/19	• CalOptima Health Education Workshop — Topic: Shape Your Life (English and Spanish)

CalOptima provided two endorsements during this reporting period (e.g., letters of support, program/ public activity events with support or use of name/logo).

1. Provide use of CalOptima logo for AltaMed's Urgent Care Centers magnets to increase awareness of urgent care centers available to members.

2. Provide a Letter of Support for Help Me Grow on behalf of Orange County Care Coordination for Kids application for Phase 4 of Lucille Packard Funding to improve access and system of care for children with special health care needs.

Back to Agenda

CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

November

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Friday, 11/1 9am-12pm	+City of Tustin Resource Fair and Flu Clinic	Health/Resource Fair Open to the Public	Registration $25 1 Staff	Tustin Area Senior Center 200 S. C. St. Tustin

Saturday, 11/2 9:30-11:30am	*CalOptima OneCare Connect Retention Event	Community Presentation Health/Resource Fair Open to the Public	10 Staff	Delhi Community Center 505 E. Central Ave. Santa Ana
Monday, 11/4 1-4pm	++OCHCA Mental Health Services Act Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 11/5 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Downtown Anaheim Community Center 250 E. Center St. Anaheim
Thursday 11/7 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 11/7 9-10:30am	++Refugee Forum of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Friday, 11/8 8:30am-2:30pm	+OC Women's Health Project 7th Annual Health Summit	Conference Open to the Public Registration required.	Sponsorship $1,000 2 Staff	University California, Irvine 100 Academy Way Irvine
Friday, 11/8 9am-12pm	+Institute for Healthcare Advancement Senior Week Health and Wellness Fair	Health/Resource Fair Open to the Public	Registration Fee $150 2 Staff	L a Habra Community Center 101 W. La Habra Blvd.

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

				La Habra
Friday, 11/8 9-10am	+OC Diabetes Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Health Care Agency 1725 W. 17th St. Santa Ana
Monday, 11/11 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 11/11 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday-Thursday 11/12-11/14 8am-4pm	+California Assoc. for Adult Day Services Fall Conference and Annual Meeting	Conference Open to the Public Registration required.	Registration Fee $850 2 Staff	Marriott Torrance Redondo Beach 3635 Fashion Way Torrance
Tuesday, 11/12 9-10:30am	++OC Strategic Plan for Aging Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 11/12 10-11:30am	++OC Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 11/12 3:30-5:30pm	++San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente

Wednesday, 11/13 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 11/13 3:30-4:30pm	++OC Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 11/14 10-11am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Thursday, 11/14 11:30am-12:30pm	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 11/14 3:30-5:30pm	++State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. 4th St. Santa Ana
Saturday, 11/16 7:30am-2pm	+Alzheimer's OC Annual Alzheimer's Latino Conference	Conference Health/Resource Fair Open to the Public	Sponsorship $3,000	Templo Calvario Church 2501 W. 5th St. Santa Ana
Tuesday-Thursday 11/19-11/21	+California Assoc. of Area Agencies of Aging Annual Meeting and Allied Conference	Conference Health/Resource Fair Open to the Public	Registration Fee $620 2 Staff	Hilton North Glendale Hotel 100 W. Glenoaks Blvd. Glendale

Tuesday, 11/19 10-11:30am	++North OC Senior Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 11/19 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 11/20 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 11/20 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 11/20 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Thursday, 11/21 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 11/21 12:30-1:30pm	++Kid Health Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana

Saturday, 11/23 9am-1pm	+St. Joseph Community Health Fair	Health/Resource Fair Open to the Public	2 Staff	Vietnamese Catholic Center 1538 Century Blvd. Santa Ana
Monday, 11/25 12:30-1:30pm	++Stanton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 11/26 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Thursday, 11/28 1-3pm	++Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana