NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, APRIL 1, 2021
2:00 P.M.

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

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Isabel Becerra, Vice Chair
Supervisor Doug Chaffee	Clayton Chau, M.D.
Clayton Corwin	Mary Giammona, M.D.
Victor Jordan	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	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 identifying the item 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 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 materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima website at www.caloptima.org.

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1) **Listen to the live audio at +1 (415) 655-0052 Access Code: 206-589-595 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/2866473406957971726 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. Chief Medical Officer Appointment
   b. Strategic Initiatives
   c. COVID-19 Response
   d. California Advancing and Innovating Medi-Cal (CalAIM)
   e. Virtual Legislative Update
   f. CalOptima/CalFresh Collaboration
   g. Federal Public Charge Rule Change

2. Chief Medical Officer Updates
   a. COVID-19 Update

3. California Advancing and Innovating Medi-Cal (CalAIM) Update

4. Introduction to the FY 2021-22 CalOptima Budget: Part 1

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
5. Minutes
   a. Approve Minutes of the March 4, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the October 22, 2020 Regular Meeting of the CalOptima Board of Directors OneCare Connect Member Advisory Committee and the Minutes of the December 10, 2020 Special Joint Meeting of the Member Advisory, Provider Advisory, OneCare Connect Member Advisory and the Whole-Child Model Family Advisory Committees

6. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee increasing the size from three seats to four seats

7. Consider Modifications to CalOptima Pharmacy Management Policies and Procedures in connection with CalOptima's regular review process and consistent with regulatory requirements to Policies MA.6106 Medication Therapy Management [OneCare, OneCare Connect] and GG.1401 Pharmacy Authorization Process [Medi-Cal]

8. Consider Actions Related to COVID-19 Vaccines for CalOptima Direct and CalOptima Community Network Members with AltaMed Health Services Corporation, Rx Consultants Group, Inc., and Community Health Centers: Ratify a.) Amendment to the AltaMed Health Services Corporation Fee-For-Service Physician Medi-Cal Contract, reflecting new terms for administration of the COVID-19 vaccine to CalOptima Direct and CalOptima Community Network members; b.) Memorandum of Understanding with Rx Consultants Group, Inc. (Mercy Medical Center Pharmacy), for the provision of COVID-19 vaccines to CalOptima members; and Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Fee-For-Service Physician Medi-Cal Contracts of all Community Health Centers to reflect new terms for administration of the COVID-19 vaccine to CalOptima Direct-Administrative and CalOptima Community Network members, based on their eligibility to administer the vaccine

9. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event: Authorize expenditures up to $10,000 for Age Well Senior Services, Inc. Virtual Senior Summit 2021 "Safe and Healthy Senior Living in the Age of COVID-19" in May 2021; Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures

10. Receive and File:
    a. February 2021 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

CLINICAL OPERATIONS

11. Consider Ratification of Contract with Medical Review Institute of America, LLC (MRIoA) for Clinical Medical Record Review Services and Reallocate Budgeted but Unspent Salary Dollars to Fund These Services; Ratify contract with MRIoA, effective March 1, 2021, through June 30, 2021, to support timely and compliant completion of authorization requests, appeals, peer reviews and special investigations; and Authorize reallocation of budgeted but unused funds of up to $120,000 from Medical Management – Salaries to Medical Management – Professional Fees to support services provided by MRIoA through June 30, 2021

PUBLIC AFFAIRS

12. Consider Approval of CalOptima's 2021–22 Legislative Priorities and 2021–22 Legislative Platform; Adopt CalOptima's 2021–22 Legislative Priorities; Adopt CalOptima's 2021–22 Legislative Platform; and Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the 2021–22 Legislative Priorities and Legislative Platform and provide regular progress reports to the Board of Directors

QUALITY/POPULATION HEALTH MANAGEMENT

13. Consider Receiving and Filing CalOptima's 2020 Quality Improvement Program Evaluation

14. Consider Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

ADVISORY COMMITTEE UPDATES

15. Joint Meeting of the Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and the Whole-Child Model Family Advisory Committees Update

16. Whole-Child Model Family Advisory Update

BOARD MEMBER COMMENTS

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on April 1, 2021 at 2:00 PM PDT at: https://attendee.gotowebinar.com/register/2866473406957971726

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

   Note: This link should not be shared with others; it is unique to you.

   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose** one of the following **audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR--

   TO USE YOUR TELEPHONE:

   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

   United States: +1 (415) 655-0052

   Access Code: 206-589-595

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	March 24, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — April 1, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Names Emily Fonda, M.D., Chief Medical Officer
I am pleased to announce that Emily Fonda, M.D., has been promoted to Chief Medical Officer. Dr. Fonda is a highly respected physician and valued member of the CalOptima organization. She has been with CalOptima for more than seven years as a Medical Director, Deputy Chief Medical Officer and most recently as Interim Chief Medical Officer. During this time, she has contributed to many successful projects and initiatives that have enabled CalOptima to lead California in Medi-Cal quality. Previously, she was in private practice for nearly 20 years and held leadership positions with multiple health care organizations, including Hoag Memorial Hospital, while also completing her Master of Medical Management degree at the University of Southern California.

Strategic Initiatives Take Shape With Input From Board Advisory Committees
As directed by your Board, on March 11, Chapman Consulting and CalOptima Strategic Development staff facilitated a discussion during the joint meeting of the Board advisory committees. The discussion focused on four strategic initiative categories highlighted at your February Board meeting: Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health. During the meeting, committee members provided feedback on the purpose statements for the four categories and potential initiatives. Staff will revise and enhance the purpose statements based on committee members' feedback and plans to continue the discussion at the April committee meetings. Staff expects to share an update at the June 3 Board meeting.

CalOptima's COVID-19 Response Continues as Vaccination Efforts Accelerate
CalOptima has intensified communication activities to encourage vaccination against COVID-19, and staff is approaching this priority using a variety of methods. Below are summaries of selected efforts on vaccination and other issues related to the pandemic.

- *Texting Campaign:* CalOptima's COVID-19 vaccine mobile texting program will launch on March 24. Texts will be sent in all threshold languages to all health network members. The Department of Health Care Services-approved message is as follows: *Hello from CalOptima. The COVID-19 vaccine has been approved by the nation's top medical experts to be safe and effective. Access to the vaccine will be based on risk and COVID-19 exposure. The vaccine will be provided at no cost to you. Stay informed. Keep wearing your mask. For information on COVID-19 Vaccine Resources. Reply Help for help or STOP to unsubscribe. Message and*

Back to Agenda

data rates apply. The campaign will continue with texts that address the eligible tiers for vaccination and where to get vaccinated.

- *"Explainer" Video Series:* CalOptima debuted the first of a new animated video series that explains important COVID-19 topics in an easy-to-understand format. The video breaks down how to receive a CalOptima Health Reward for getting vaccinated. It is posted on our website and was distributed via social media. The next "explainer" video will address post-vaccination safety.
- *Social Media Advertising Campaign*: In late March, CalOptima launched digital ads on social media platforms, including Facebook (16 ads), Instagram (16 ads) and YouTube (8 ads). The ads target women, people 35–54 years old, Latinos and African Americans, which are groups known to have more vaccine hesitancy. The ad concepts share that COVID-19 vaccines are safe and effective, can help a person connect with family sooner, and are good for the community.
- *Kid Healthy COVID-19 Vaccination Education*: On March 18, Medical Director Miles Masatsugu, M.D., participated in a COVID-19 vaccination information session on Zoom and Facebook Live sponsored by Kid Healthy, a nonprofit organization based in Santa Ana focused on reducing childhood obesity. The event was geared toward parents to encourage vaccination and address vaccine hesitancy in Kid Healthy's largely Latino audience.
- *Nursing Home Webinar:* As part of our Orange County Nursing Home COVID-19 Infection Prevention program, UCI infectious disease experts presented a webinar to address advanced vaccine questions. More than 60 nursing home representatives attended the March 10 event. Like prior webinars, it is posted on the program's website here.
- *Vaccine Equity Pilot Program:* As of March 23, CalOptima has collaborated with the Orange County Health Care Agency to directly allocate approximately 44,500 doses of COVID-19 vaccine to community health centers and health network providers. CalOptima has asked health networks to report vaccine administration within 24 hours to the California Immunization Registry and aim for 100% vaccine utilization within each week.
- *PBS Public Service Announcements:* Based on CalOptima's previous PBS sponsorship related to preventive health care, PBS invited us to partner with the Y on three public service announcements focused on senior isolation during COVID-19. Taped on March 18, these spots feature Edwin Poon, Ph.D., director of Behavioral Health Services, offering strategies to support seniors' mental health. The messages will debut in April.
- *Media Coverage:* The February 22 print edition of national magazine Modern Healthcare featured information and photographs about CalOptima's PACE Without Walls program within a larger story about COVID-19. A similar article also ran on the magazine's website.

Board to Receive California Advancing and Innovating Medi-Cal (CalAIM) Presentation
CalAIM is a multiyear initiative to improve Medi-Cal beneficiaries' quality of life and health outcomes by implementing delivery system, program and payment reforms that reduce complexity and increase flexibility. At your April 1 Board meeting, Rachel Selleck, Executive Director, Public Affairs, will provide an overview of the initiative and CalOptima's possible approach to the CalAIM programs that will be implemented first, Enhanced Care Management (ECM) and In Lieu of Services (ILOS), which both have a proposed effective date of January 1, 2022. Further, staff have been raising awareness about CalAIM among CalOptima's provider and community partners. This will culminate in a stakeholder meeting being planned for May.

Back to Agenda

Virtual Legislative Update Engages Elected Officials' Staff, Other Partners
On March 12, CalOptima's Government Affairs department hosted a Virtual Legislative Update for members of the Orange County delegation and CalOptima's Board advisory committees. Nearly 40 staffers from elected officials' offices and advisory committee members attended for an update regarding CalOptima's COVID-19 response, legislative priorities and process for handling constituent issues.

Partnership Aims at Expanding CalFresh Enrollment, Increasing Awareness About CalOptima in Orange County
CalOptima is collaborating with the Orange County Social Services Agency (SSA) to increase awareness about Medi-Cal and CalFresh benefits. Staff recently learned that Orange County enrollment in CalFresh runs lower than the state average by approximately 10%. While CalFresh has stricter income levels and immigration status requirements, most CalOptima members would typically meet CalFresh eligibility criteria. Strategies being considered are outreach to members/participants, communication to community-based organizations and providers, and education for member-facing CalOptima and health network staff. Access to healthy food is a challenge that has only increased during the pandemic. We look forward to partnering with SSA to address this social determinant of health.

Restrictive 2019 Federal Public Charge Rule to Be Set Aside
On March 15, the U.S. Department of Homeland Security announced that it will return to using policies in place before the 2019 Public Charge Final Rule. That means immigrants can seek and accept medical care, food assistance and public housing without consequences related to public charge. U.S. Citizenship and Immigration Services will not consider participation in Medi-Cal (except for long-term care), public housing or CalFresh as part of the public charge determination. Testing, treatment and preventive services for COVID-19, including vaccines, are not considered for public charge purposes. California health and human services leaders issued a joint statement in response to the federal public charge changes.

Back to Agenda

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COVID-19 Update

Board of Directors Meeting
April 1, 2021

Emily Fonda, M.D., MMM, CHCQM
Chief Medical Officer

Back to Agenda

COVID-19 Efforts in Progress

- Member Incentive Implementation
  - Number of gift cards sent
- Member Vaccination Strategy
  - Number of members vaccinated
  - Eligibility update
  - Blue Shield update

Back to Agenda

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Back to Agenda

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California Advancing and Innovating Medi-Cal (CalAIM)

Board of Directors Meeting

April 1, 2021

Rachel Selleck, Executive Director, Public Affairs

Back to Agenda

Background

Whole Person Care
(2016–21)
- Lead Entity: County of Orange
- Services:
  - Housing Navigation and Sustainability (includes housing deposits)
  - Recuperative Care

Health Homes Program
(2020–21)
- Lead Entity: CalOptima
- Services:
  - Comprehensive Care Management*
  - Housing Navigation and Sustainability

California Advancing & Innovating Medi-Cal (CalAIM)
(2022–27)
- Target Implementation Phase 1: January 2022
- Lead Entity: CalOptima
- Services:
  - Enhanced Care Management**
  - Phase 1 In Lieu of Services (ILOS):
    - Housing Transition Navigation Services
    - Housing Tenancy and Sustaining Services
    - Housing Deposits
    - Recuperative Care

* **Comprehensive Care Management:** Care management addressing primarily clinical needs

** **Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

Back to Agenda

Note: Concurrently planning for Phase 2 ILOS services to launch in July 2022.

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Background (cont.)

- CalAIM Enhanced Care Management (ECM) benefit intensifies care management and builds on current Whole Person Care (WPC) pilot and Health Homes Program (HHP) for high-need Medi-Cal beneficiaries

- January 2021: Department of Health Care Services (DHCS) released revised CalAIM proposal

- Expands Medi-Cal Managed Care Plans' responsibilities and provides opportunities for enhanced care

Back to Agenda

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Primary Goals of CalAIM

- Improve member and provider experience
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation

Sources: DHCS CalAIM site: www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

CalAIM Proposal: www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-02172021.pdf

Back to Agenda

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CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

Back to Agenda

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Enhanced Care Management (ECM)

- Implement a single, intensive and comprehensive ECM benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Build upon current WPC and HHP delivery systems
- Use phased implementation approach

Date	Population
January 2022	Existing WPC/HHP target populations
July 2022	Additional target populations

Back to Agenda

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ECM Target Populations

- Children and youth with complex conditions
- Individuals experiencing chronic homelessness with complex conditions
- High health care system utilizers
- Nursing facility residents
- Individuals at risk for institutionalization who are either eligible for long-term care or have co-occurring chronic conditions
- Individuals transitioning from incarceration

Note: WPC and HHP members overlap within these target populations; ECM target populations are subject to change, per DHCS guidance

Back to Agenda

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CalOptima's ECM Proposal

- To align with CalAIM expectations of integrating WPC and HHP under ECM:
  - Leverage HHP Community-Based Care Management Entities (CB-CMEs) to serve as ECM providers to ensure continuity of care
    - Delegate ECM to health networks as they act as CB-CME for HHP
- Allows members to stay with their health network and minimizes care disruption
- **Funding**: Anticipate State funding

Back to Agenda

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In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

Back to Agenda

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DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

Back to Agenda

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CalOptima's ILOS Proposal

- To maintain continuity of care, CalOptima (as a carve-out) to offer the following ILOS services currently provided under WPC and HHP (Phase 1):
  - Housing Transition Navigation Services** (WPC, HHP)
  - Housing Tenancy and Sustaining Services** (WPC, HHP)
  - Housing Deposits (WPC)
  - Recuperative Care (Medical Respite) (WPC)
- **Service Providers**: Maintain current providers (through Letters of Agreement or contracts) while RFPs are developed
- **Funding**: IGT/Reserve monies (no anticipated State funding) until savings are realized

** Currently delegated to health networks through HHP

Back to Agenda

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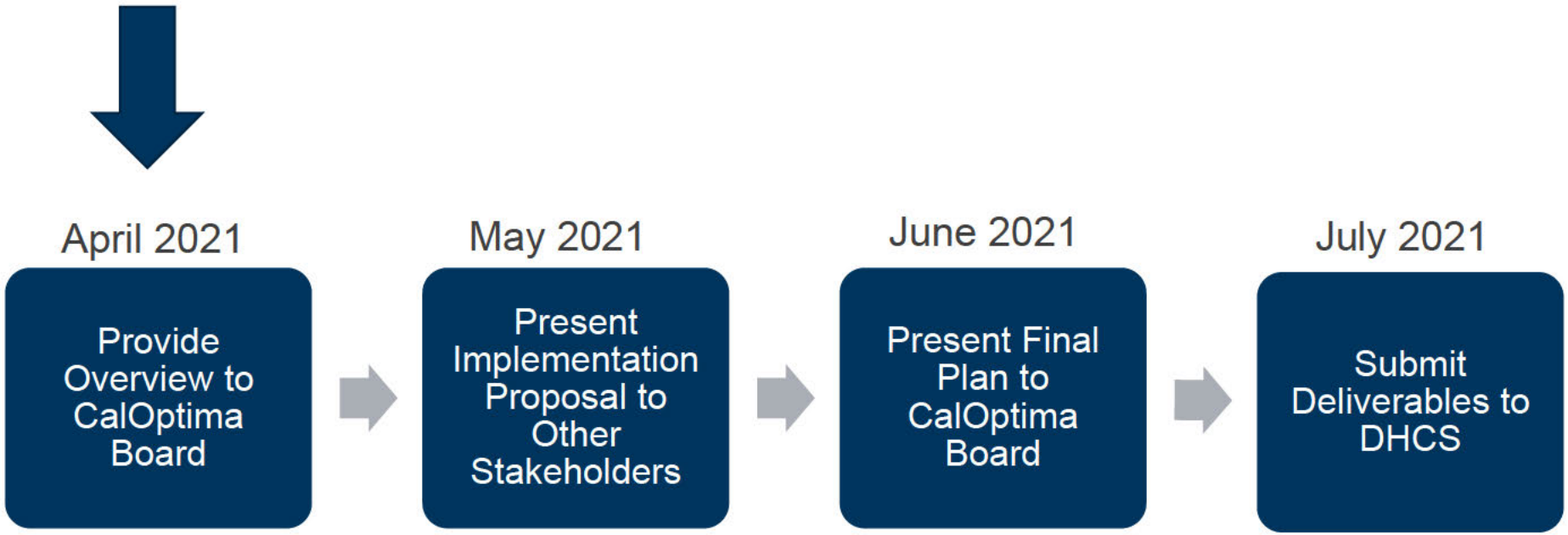
Next Steps



Back to Agenda

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Back to Agenda

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Introduction to the Fiscal Year 2021-22 CalOptima Budget: Part 1

Board of Directors Meeting
April 1, 2021

Nancy Huang, Chief Financial Officer

Back to Agenda

Overview

- Budget Components
- Lines of Business
- Operating Budget Overview
  - Preliminary Enrollment Projections
  - Revenue Assumptions
  - Medical Costs
  - Administrative Expenses
- Capital Budget Overview
- Fiscal Year (FY) 2021-22 Anticipated Medi-Cal Revenue Impact
- FY 2021-22 Budget Considerations
- Budget Process and Board Approval Timelines

Back to Agenda

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Budget Components

Operating Budget

- Enrollment
- Revenue
- Medical Costs
- Administrative Expenses

Capital Budget

- Information Systems
- 505 Building Improvements
- PACE Center

Back to Agenda

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Lines of Business

	Start Date	Program Type	Contractor/ Regulator
Medi-Cal CalOptima Better. Together.	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
OneCare (HMO SNP) CalOptima Better. Together.	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
PACE CalOptima Better. Together.	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
OneCare Connect CalOptima Better. Together.	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

Medi-Cal Program includes (1) Classic, (2) Medi-Cal Expansion and (3) Whole Child Model.

MSSP program included under Medi-Cal. Beginning January 2022, MSSP will be carved-out of Medi-Cal.

Back to Agenda

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Operating Budget Overview: Enrollment

- Medi-Cal enrollment defined by eligibility for aid
  - Adult, Children, Medi-Cal Expansion, Seniors and Persons with Disabilities (SPD), Long Term Care (LTC), Dual eligible (i.e., eligible for Medicare and Medi-Cal)
  - Whole Child Model (WCM) enrollment included in Medi-Cal
- OneCare Connect and OneCare enrollment cohorts defined by medical condition and services received
  - Medicare: Aged, End-stage Renal Disease, Hospice
  - Medi-Cal: Institutional, Community-Based Adult Services /Multipurpose Senior Services Program, In-Home Supportive Services, Community Well
- PACE enrollment defined by program eligibility
  - Dual eligible, Medi-Cal only, Non-Medi-Cal enrollment

Back to Agenda

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Preliminary Enrollment Projection: Summary

TOTAL MEMBER MONTHS

LOB	FY 2019	FY 2020	FY 2021	FY 2022	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/'20 Δ (#)	'21/'20 Δ (%)	'22/'21 Δ (#)	'22/'21 Δ (%)
MC	9,016,714	8,687,701	9,490,270	9,865,125	(329,013)	-3.65%	802,569	9.24%	374,855	3.95%
OCC	173,590	170,475	177,698	180,337	(3,115)	-1.79%	7,223	4.24%	2,639	1.49%
OC	17,334	17,515	19,651	20,856	181	1.04%	2,136	12.20%	1,205	6.13%
PACE	3,632	4,569	4,671	4,953	937	25.80%	102	2.23%	282	6.04%
TOTAL	**9,211,270**	**8,880,260**	**9,692,290**	**10,071,271**	**(331,010)**	**-3.59%**	**812,030**	**9.14%**	**378,981**	**3.91%**

MEMBERSHIP (JUNE OF EACH FISCAL YEAR)

LOB	FY 2019	FY 2020	FY 2021	FY 2022	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/'20 Δ (#)	'21/'20 Δ (%)	'22/'21 Δ (#)	'22/'21 Δ (%)
MC	739,788	742,641	818,182	810,792	2,853	0.39%	75,541	10.17%	(7,390)	-0.90%
OCC	14,194	14,396	14,950	14,881	202	1.42%	554	3.85%	(69)	-0.46%
OC	1,533	1,452	1,738	1,701	(81)	-5.28%	286	19.70%	(37)	-2.13%
PACE	326	391	392	440	65	19.94%	1	0.26%	48	12.24%
TOTAL	**755,841**	**758,880**	**835,262**	**827,814**	**3,039**	**0.40%**	**76,382**	**10.07%**	**(7,448)**	**-0.89%**

**Based on Actuals 201807 through 202102*

Note: State anticipates Public Health Emergency will end by December 31, 2021.

Back to Agenda

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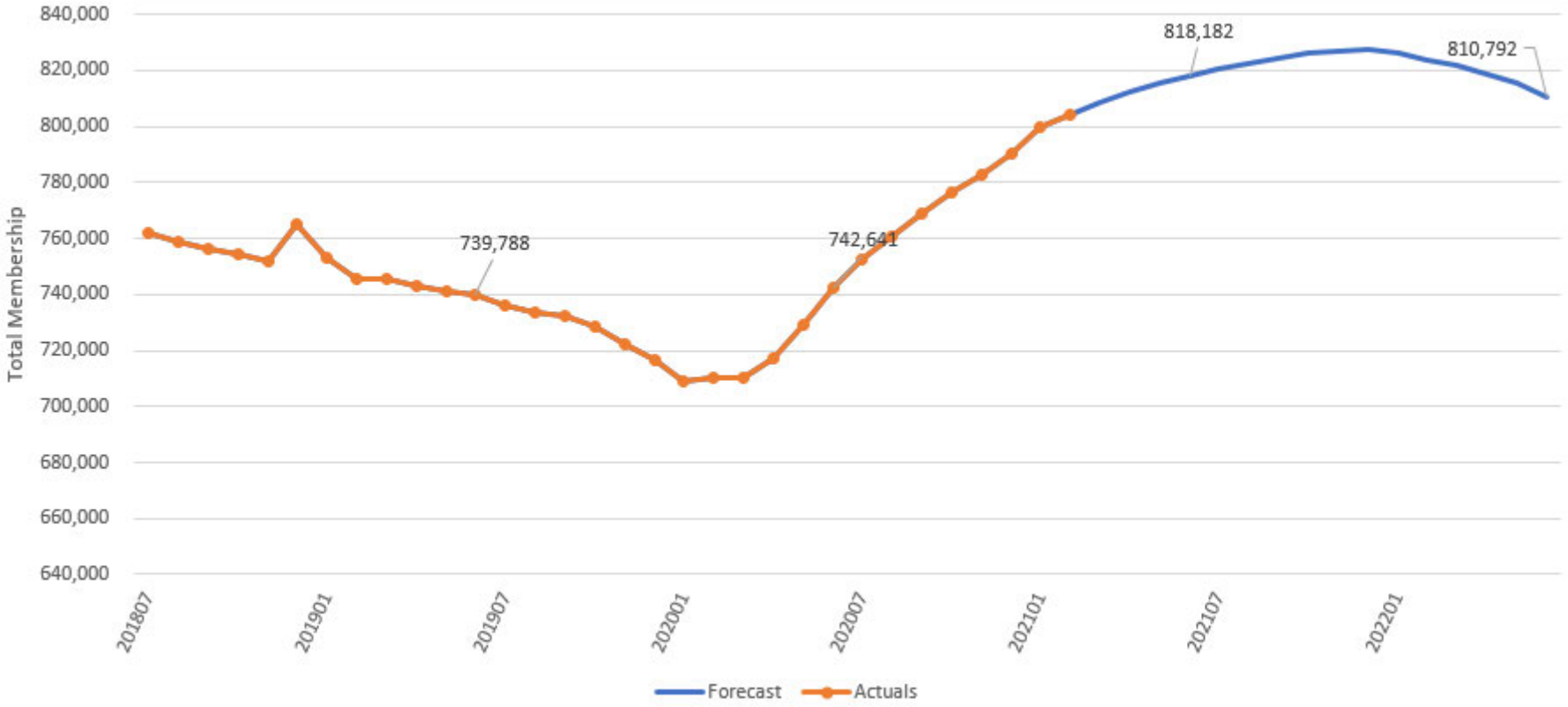
Preliminary Enrollment Projection: Total Medi-Cal



Note: Preliminary FY 2021-22 Forecast; subject to change with additional information and/or change in assumptions
Total Medi-Cal enrollment includes Medi-Cal Classic, Medi-Cal Expansion, and WCM members
Medi-Cal Expansion enrollment is ~35% of total; WCM <2%

Back to Agenda

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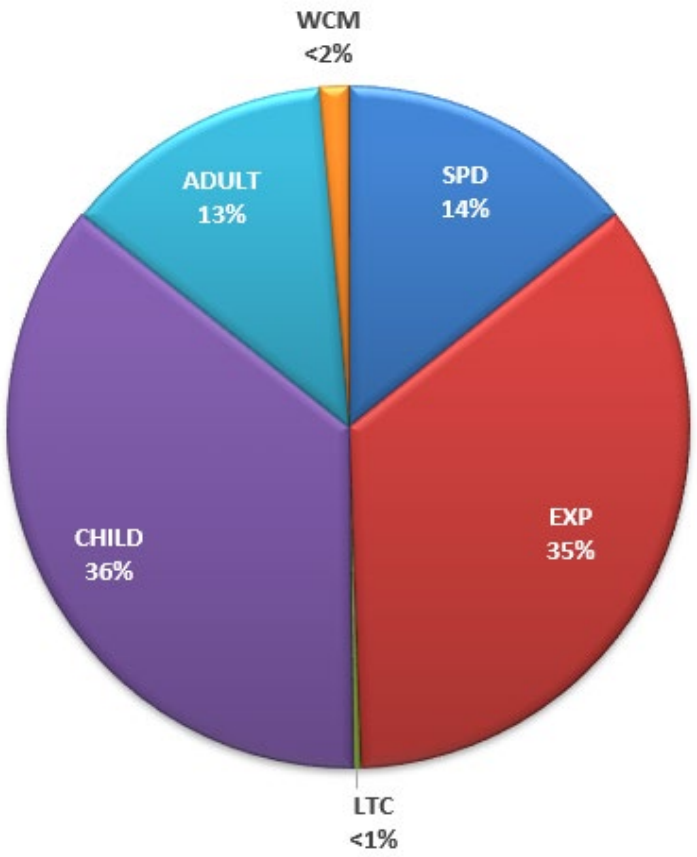
Medi-Cal Enrollment by Category of Aid

- Medi-Cal enrollment defined by eligibility for aid
  - Seniors or Persons with Disabilities
  - Medi-Cal Expansion
  - Long Term Care
  - Child
  - Adult
  - Whole Child Model



Note: Forecasted FY 2021-22 enrollment (as of March 2021); subject to change with additional information and/or change in assumptions

Back to Agenda

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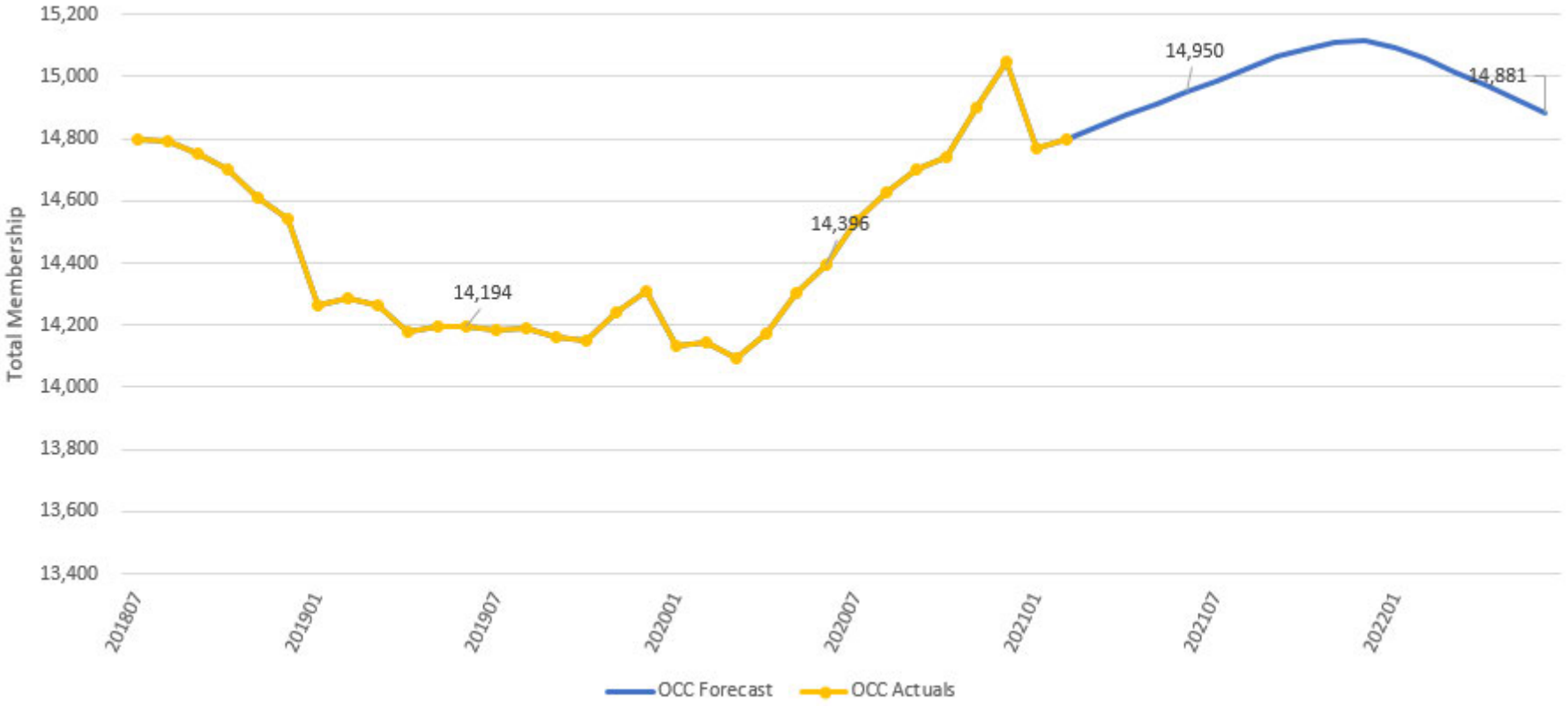
Preliminary Enrollment Projection: OneCare Connect



Note: Preliminary FY 2021-22 Forecast; subject to change with additional information and/or change in assumptions

Back to Agenda

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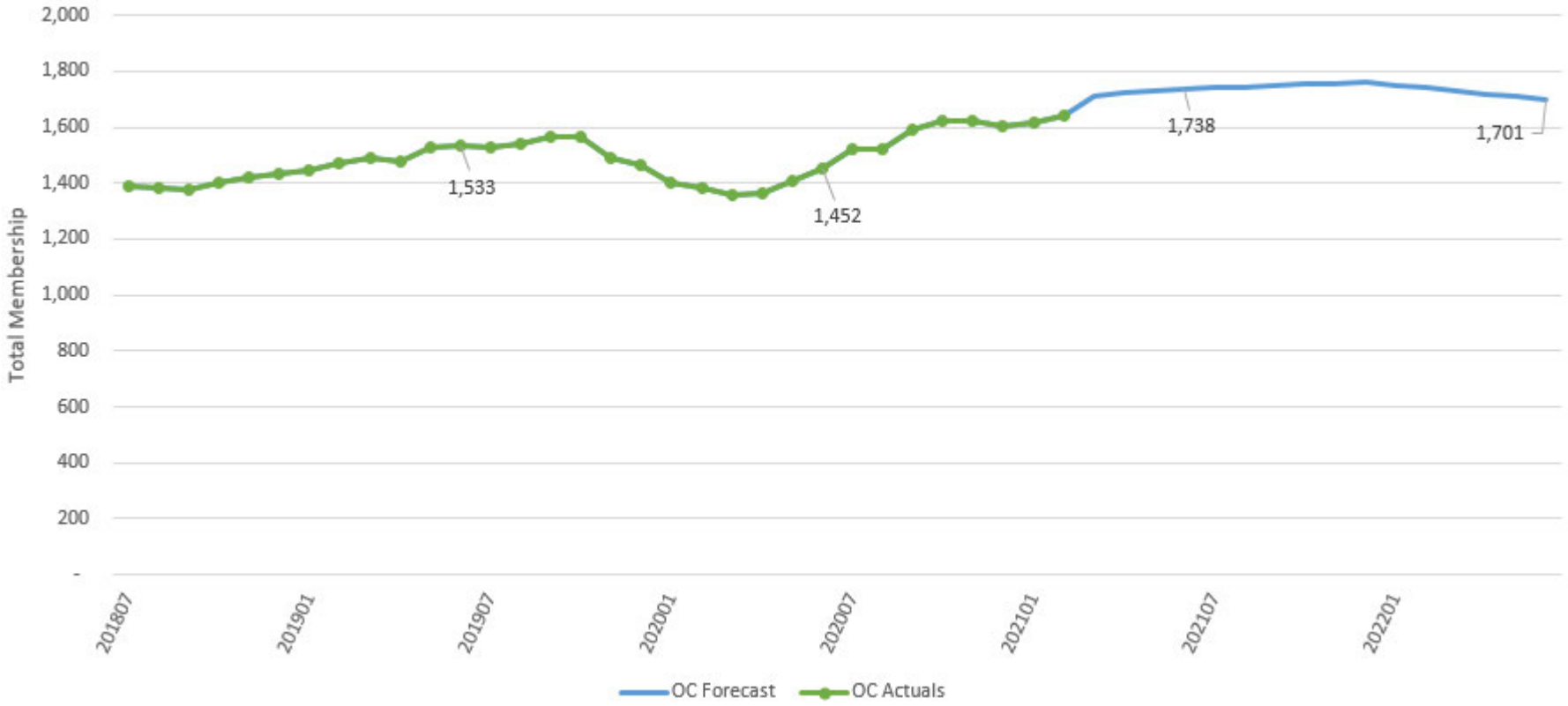
Preliminary Enrollment Projection: OneCare

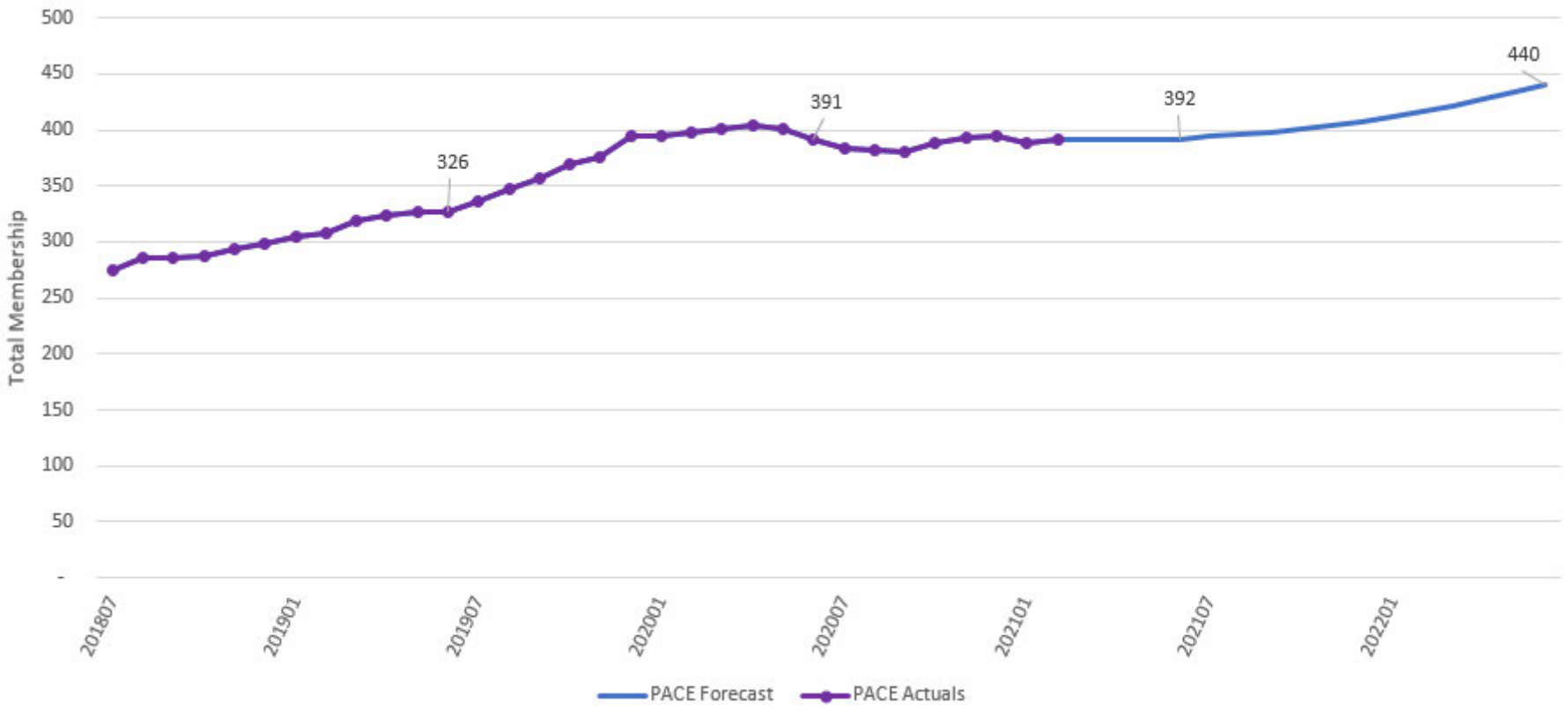


Note: Preliminary FY 2021-22 Forecast; subject to change with additional information and/or change in assumptions

Back to Agenda

CalOptima
A Public Agency

Preliminary Enrollment Projection: PACE



Note: Preliminary FY 2021-22 Forecast; subject to change with additional information and/or change in assumptions

Back to Agenda

CalOptima
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Revenue: Medi-Cal

- Enrollment drives revenue
  - Different revenue rates for each aid category
  - Some supplemental revenue for Behavioral Health Treatment, Hepatitis C drugs and Health Homes Program (HHP)

- DHCS provides or removes funding for programs and benefits
  - Examples: WCM, HHP, Proposition 56, Enhanced Care Management, Medi-Cal Rx
  - Uncertainties/risks associated with new revenue
    - Correct pricing and adequacy of funding to deliver services
    - Timeliness of funding is unpredictable; will impact cash flow and reserves

Back to Agenda

CalOptima
A Public Agency

Revenue: Medi-Cal (cont.)

- Timing of rate releases
  - Medi-Cal contract rates on calendar year basis
    - Expect to receive CY 2022 draft rates prior to October 2021
  - Rates are not considered final until they are certified by CMS
    - Draft rates may change prior to finalization
    - Historically, final rates have been relatively close to draft rates
  - CalOptima's budget assumptions based on most current rate information available
    - Draft or estimated capitation rates are used until final rates become available
    - Example:
      - 7/1/21 – 12/31/21: Based on CY 2021 rates
      - 1/1/22 – 6/30/22: Will include estimated capitation rates based on information available

Back to Agenda

CalOptima
A Public Agency

Revenue: Medicare

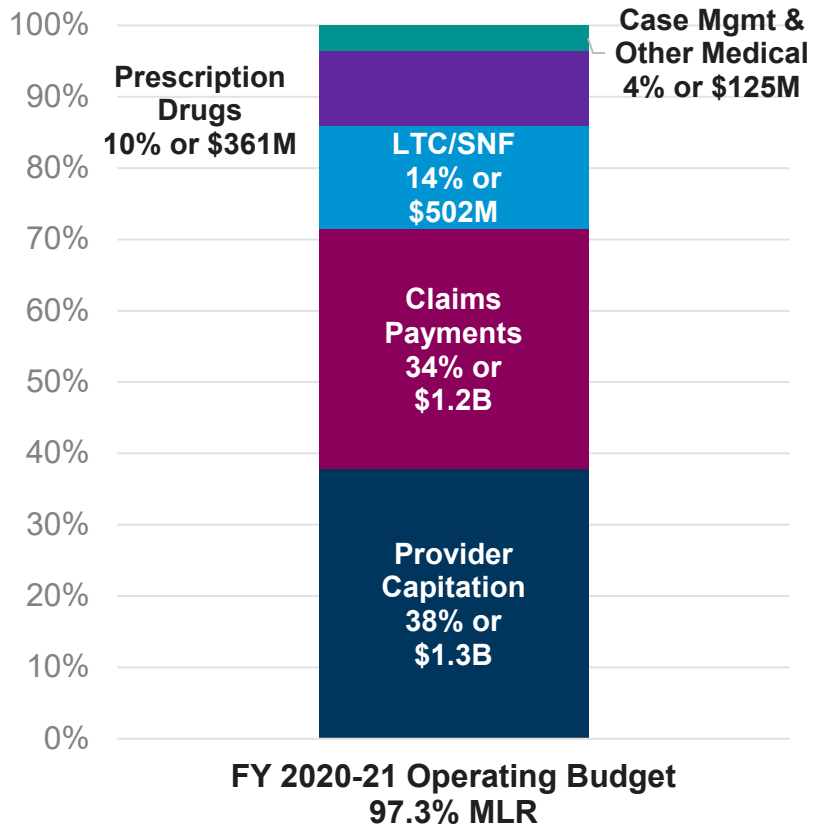
- Medicare provides funding for two components
  - Part A/B: Funding for hospital and physician services
  - Part D: Funding for prescription drugs
- Revenue is determined by two primary factors
  - Base rate: Determined via annual bid or set at fee-for-service benchmark
  - Risk Adjustment Factor: Applied to the base rate
    - Based on member's medical condition
    - Adjusts funding to match the expected expense of conditions
    - Heavily dependent on Plan's ability to collect and submit data
- Applies to OneCare Connect, OneCare and PACE

Back to Agenda

CalOptima
A Public Agency

Medical Costs

- Provider capitation payments
- Claims payments to hospitals and providers
- LTC/Skilled Nursing Facilities (SNF)
- Prescription Drugs
  - OneCare Connect, OneCare and PACE
- Case management and Other medical (i.e., care coordination activities)



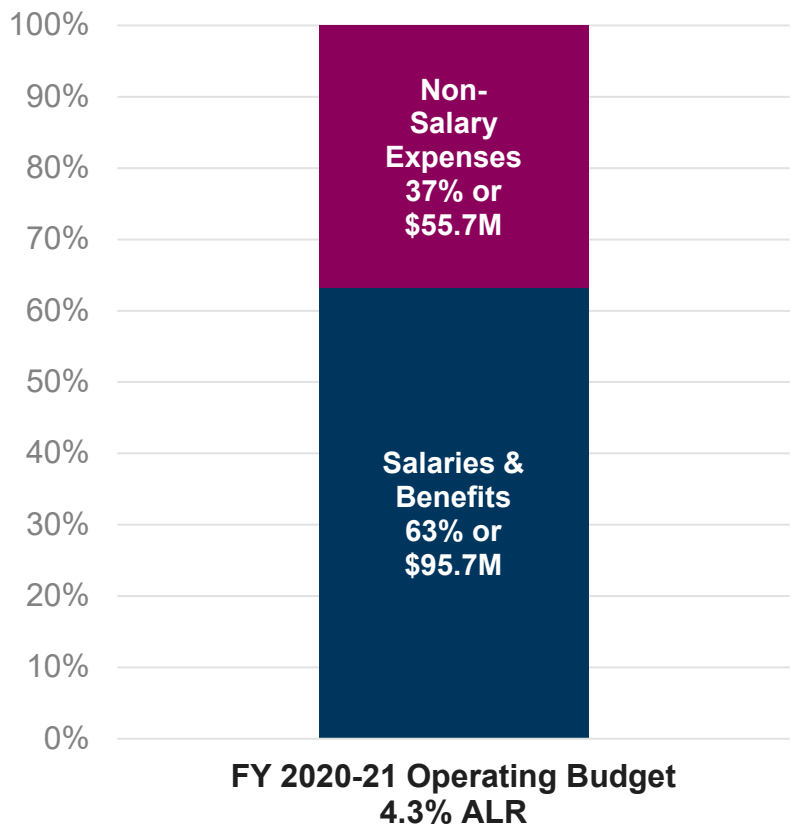
Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

Back to Agenda

CalOptima A Public Agency

Administrative Expenses

- Salaries, Wages and Employee Benefits
- Professional Fees
- Purchased services
- Printing and Postage
- Other Operating Expenses



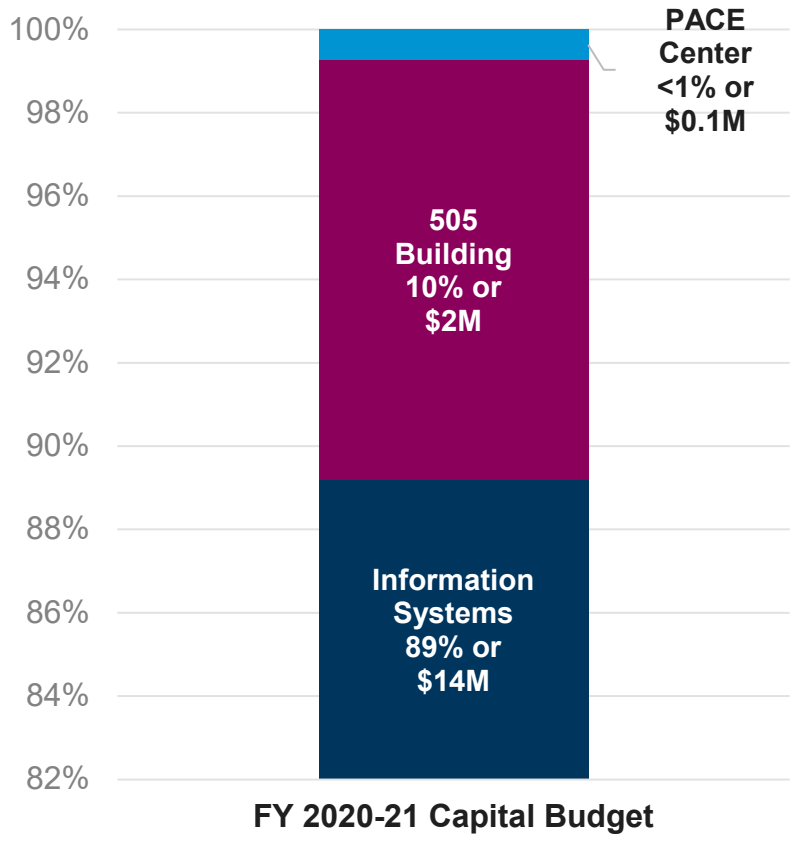
Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

Back to Agenda

CalOptima A Public Agency

Capital Budget Overview

- Information Systems: Information technology infrastructure needs
- 505 Building Improvements
- PACE Center



Source: FY 2020-21 Operating Budget (6/4/20 COBAR)

Back to Agenda

CalOptima A Public Agency

FY 2021-22 Anticipated Medi-Cal Revenue Impact

- Rate Adjustments
  - Projected rate decrease to Medi-Cal Expansion
- Program Updates
  - CalAIM: HHP/Whole Person Care transition to Enhanced Care Management and In Lieu of Services (ILOS): Effective January 2022
    - ILOS: No additional funding from the State
  - Medi-Cal Rx carve-out: To be determined; staff anticipates a January 1, 2022, effective date
  - MSSP carve-out: Effective January 2022
- COVID-19: Pre- and post-pandemic effects on all aspects of the budget

Back to Agenda

CalOptima
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FY 2021-22 Budget Considerations for FFS Provider Reimbursement

- Increase in Medi-Cal Classic Inpatient FFS
- Increase in total Medi-Cal (Classic and Expansion) Outpatient (non-pharmacy)
- Reduction to total Medi-Cal (Classic and Expansion) Outpatient Pharmacy
- Increase in Medi-Cal SNF rates

Back to Agenda

CalOptima
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FY 2021-22 Budget Considerations for Health Network Reimbursement

- Apply commensurate FFS provider adjustments to Health Network capitation rates
- Continued decrease to Medi-Cal Expansion rates to align with State's adjustments
- Re-evaluate cost trend assumptions used in previous rebasing exercise
- WCM
  - Carve-out financial risk for private-duty nursing from rates
  - Re-evaluate distribution of professional and hospital risk and re-balance capitation rates based on current experience

Back to Agenda

CalOptima
A Public Agency

Budget Preparation/Review Process

Budget Preparation

- 2/18: Budget Primer to FAC
- Late Feb – Early Mar: Departments prepare admin budgets
- Mid-Mar – End Mar: Internal review on medical and admin budget assumptions
- Early Apr: CFO reviews medical and admin budget proposals

Budget Review

- 4/1: Board Information Item on Budget Part 1
- Early Apr – Mid-Apr: Executives review proposed budget
- Late Apr: Finance finalizes and Executives approve budget
- 5/6: Board Information Item on Budget Part 2

Budget Presentation

- 5/20: FAC meeting
- 6/3: Board meeting

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Back to Agenda

Board Approval Timeline

	Date	Meeting
√	February 18, 2021	Finance and Audit Committee meeting: Present background information on FY 2021-22 Budget Primer
	April 1, 2021	Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 1
	May 6, 2021	Board of Directors meeting: Present information item on Introduction to the FY 2021-22 Budget: Part 2
	May 20, 2021	Finance and Audit Committee meeting: Present FY 2021-22 budgets
	June 3, 2021	Board of Directors meeting: Present FY 2021-22 budgets
	July 1, 2021	Beginning of Fiscal Year 2021-22

Back to Agenda

CalOptima
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Our Mission

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

Back to Agenda

CalOptima
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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

March 4, 2021

A Regular Meeting of the CalOptima Board of Directors was held on March 4, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:01 p.m. and Director Corwin led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Supervisor Doug Chaffee (at 2:07 p.m.); Clayton Chau, M.D. (non-voting); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan (at 2:07 p.m.); Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.
(All Board Members participated remotely except Chairman Do and Director Tran, who attended in person)

Members Absent: None.

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Sharon Dwiers, Clerk of the Board

Chairman Do welcomed new Board Member Nancy Shivers to the CalOptima Board and asked the Clerk to administer the ceremonial oath of office.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, welcomed Director Shivers and highlighted several items from his report. Mr. Sanchez provided an update on the pharmacy carveout, (Medi-Cal Rx), which had been delayed by the Department of Health Care Services (DHCS) from its initial implementation date of January 1, 2021. Late yesterday, CalOptima staff was informed that the state is moving forward with an April 1, 2021 implementation date and is requesting that CalOptima and other Medi-Cal Managed Care plans share certain data to facilitate this transition. Staff will keep the Board apprised of developments related to the Medi-Cal Rx program implementation.

Mr. Sanchez also provided an update on the COVID-19 vaccine effort and the state's designation of Blue Shield as the third-party administrator (TPA) assigned to manage the vaccination efforts statewide.

Back to Agenda

Director Chau, who is also the Director and Public Health Officer of the Orange County Health Care Agency, provided additional details related to the COVID-19 vaccine. Mr. Sanchez also updated the Board on the state's California Advancing and Innovating Medi-Cal (CalAIM) initiative that was delayed for approximately one year. With vaccines becoming more readily available to mitigate the effect of the COVID-19 pandemic, CalAIM is now moving forward, with important deadlines fast approaching. Staff will provide more details at the April Board meeting. Health plan CalAIM submissions are due to the state by July 1, 2021.

2. COVID-19 Update
Emily Fonda, M.D., Interim Chief Medical Officer, provided a COVID-19 update.

PUBLIC COMMENTS
There were no requests for public comment.

Chairman Do noted for the record that Director Schoeffel is not participating in Consent Calendar items 7, 16, 17, 19 and 20 due to potential conflicts of interest. Chairman Do also pulled Consent Calendar items 10, 11 and 21 for discussion.

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the February 4, 2021 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the November 19, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the December 10, 2020 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the Minutes of the October 27, 2020 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

4. Consider Reappointment to the CalOptima Board of Directors Investment Advisory Committee

5. Consider Appointment to the CalOptima Board of Directors' Member Advisory Committee

6. Consider Authorizing Modifications to CalOptima Operations Policies and Procedures

7. Consider Authorizing Modifications to CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks
Director Schoeffel did not participate in this item due to potential conflicts of interest.

8. Consider Adoption of Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan

9. Consider Adoption of a Resolution Approving Updates to CalOptima Policy GA. 8058: Salary Schedule and Actions Related to Recommendations from Independent Compensation Consultant Grant Thornton

Back to Agenda

10. Consider Receiving and Filing CalOptima's 2020 Quality Improvement Program Evaluation
This item was pulled for discussion.

11. Consider Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan
This item was pulled for discussion.

12. Consider Receiving and Filing the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation

13. Consider Approval of the 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

14. Consider Approval of the 2020 CalOptima Utilization Management Program Evaluation and the 2021 CalOptima Utilization Management Program Description

15. Consider Approval of Modifications to Quality Improvement Policies

16. Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program
Director Schoeffel did not participate in this item due to potential conflicts of interest.

17. Consider Ratification and Authorization of Expenditures Related to the Coronavirus Pandemic
Director Schoeffel did not participate in this item due to potential conflicts of interest.

18. Consider Ratification of Budget Reapportionment Changes in the CalOptima Fiscal Year 2019-20 Capital Budget for Various Information System Capital Projects

19. Consider Authorizing Amendments to CalOptima's Coordination and Provision of Public Health Care Services and Coordination and Provision of Behavioral Healthcare Services Agreements with the Orange County Health Care Agency
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Chau did not participate is this item due to his role as Director of the Orange County Health Care Agency.

20. Consider Authorizing Insurance Policy Procurements and Renewals for Policy Year 2021-22
Director Schoeffel did not participate in this item due to potential conflicts of interest.

21. Receive and File
   a. January 2021 Financial Summary
      This item was pulled for discussion.
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Community Outreach and Program Summary

Back to Agenda

Chairman Do split the Consent Calendar into to two separate votes.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors approved Consent Calendar Items 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, and 18 as presented. (Motion carried 9-0-0)***

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors approved Consent Calendar Items 7, 16, 17, 19, and 20 as presented. (Motion carried 6-0-0; Supervisor Chaffee and Director Schoeffel absent)***

Director Schoeffel did not participate in the second action above due to potential conflicts of interest. Director Chau did not participate in Consent Calendar Item 19 due to his role as the Director of the Orange County Health Care Agency.

10. Consider Receiving and Filing CalOptima's 2020 Quality Improvement Program Evaluation

11. Consider Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Chairman Do pulled Consent Calendar Items 10 and 11 for discussion and noted he would like to continue these two items. Chairman Do directed staff to include more innovation and member engagement. He directed staff to look for lower tech avenues to reach CalOptima members, adding that we should find ways to bridge the "digital divide."

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors continued Consent Calendar Items 10 and 11 and directed staff to incorporate the Board's suggestions and bring back to the Board for consideration. (Motion carried 8-0-0; Supervisor Chaffee absent)***

21. Receive and File

a. January 2021 Financial Summary

Chairman Do pulled this item for discussion and directed staff to Slide 4 of the presentation, specifically the Balance Sheet. He directed staff to provide details on the various categories of dollars that are included in CalOptima's net position to provide a clearer idea of dollars in each category and what these funds can and cannot be spent on, with explanations.

b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Consent Calendar Item 21 was received and filed as presented.

REPORTS

22. Consider Approval of CalOptima's 2021–2022 Legislative Platform

Chairman Do pulled this item and recommended that CalOptima follow the County's format and use more narrow and focused categories.

Back to Agenda

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors continued this item and directed staff to revise and bring back to the Board for further consideration. (Motion carried 8-0-0; Supervisor Chaffee absent)***

23. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted to Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest based on campaign contributions under the Levine Act and passed the gavel to Vice Chair Becerra. Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Jordan did not participate in this item due to his affiliation with Providence St. Joseph Healthcare.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Authorized a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and 2.) Authorized the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase. (Motion carried; 5-0-1; Chairman Do abstained; Supervisor Chaffee, Directors Jordan and Schoeffel absent)***

Report Item 24 was skipped momentarily to allow time to address technical difficulties.

Vice Chair Becerra passed the gavel back to Chairman Do.

25. Consider Actions Related to the CalOptima Program of All-Inclusive Care for the Elderly and Multipurpose Senior Services Program Non-Medical Ancillary Fee-For-Service Contracts

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Jordan did not participate in this item due to his affiliation with Providence St. Joseph Healthcare.

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into amendments to the Program of All-Inclusive Care for the Elderly (PACE) and Multipurpose Senior Services Program (MSSP) non-medical ancillary Fee-For-Service (FFS) provider contracts to reflect standardized payment rates to be effective on or after March 4, 2021; and 2.) Authorized the CEO to develop and implement standardized payment rates for PACE and MSSP non-medical ancillary FFS provider contracts. (Motion carried 6-0-0; Supervisor Chaffee, Directors Jordan and Schoeffel absent)***

26. Consider Authorizing Memorandum of Understanding with the County of Orange Social Services Agency Related to In-Home Supportive Services

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Back to Agenda

Chairman Do recommended continuing this item until after the draft MOU has been prepared.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors continued this item and directed staff to include the MOU and bring back to the Board for consideration. (Motion carried 8-0-0; Director Schoeffel absent)***

27. Consider Authorizing a Contract with eVisit Services Vendor
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Chairman Do recommended continuing this item and asked that staff include the contract in the Board materials packet.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors continued this item and directed staff to include the contract and bring back to the Board for consideration. (Motion carried 8-0-0; Director Schoeffel absent)***

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest based on campaign contributions under the Levine Act and passed the gavel to Vice Chair Becerra. Directors Schoeffel, Shivers and Tran did not participate in this item due to conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Authorized a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and 2.) Authorized the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase. (Motion carried 5-0-1; Chairman Do abstained; Directors Schoeffel, Shivers and Tran absent)***

Vice Chair Becerra passed the gavel back to Chairman Do.

ADVISORY COMMITTEE UPDATES

Due to technical difficulties the Advisory Committee Updates were heard out of order.

29. Member Advisory Committee Update
Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on MAC activities and welcomed Director Shivers.

Back to Agenda

28. Provider Advisory Committee Update

Dr. John Nishimoto, Provider Advisory Committee (PAC) Vice Chair, provided an update on PAC activities.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Giammona thanked Chairman Do and Richard Sanchez for their work on behalf of Board and CalOptima's members.

CLOSED SESSION

The Board of Directors adjourned to closed session at 4:04 p.m. pursuant to Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment.

ADJOURNMENT

The Board adjourned from closed session at 4:40 p.m. with no reportable action taken and the meeting was adjourned.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: April 1, 2021

Back to Agenda

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

October 22, 2020

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on October 22, 2020, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:03 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair; Meredith Chillemi; Gio Corzo; Josefina Diaz; Sandra Finestone; Eleni Hailemariam, M.D. (non-voting); Sara Lee; Mario Parada; Donald Stukes

Members Absent: Jyothi Atluri (non-voting)

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Deputy Chief Medical Officer; Belinda Abeyta, Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director, Clinical Operations; TC Roady, Director, Regulatory Affairs; Albert Cardenas, Director, Customer Service; Andrew Tse, Associate Director, Customer Service, Cheryl Simmons, Staff to the Advisory Committees; Praveena Lal, Administrative Assistant, Customer Service.

MINUTES

Approve the Minutes of the August 27, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Josefina Diaz, seconded and carried, the Committee approved the minutes of the August 27, 2020 meeting by a roll call vote. (Motion carried 9-0-0)***

Back to Agenda

Approve the Minutes of the October 8, 2020 Joint Meeting of the CalOptima Board of Directors' Board Advisory Committees

Action: ***On motion of Member Mario Parada, seconded and carried, the Committee approved the minutes of the October 8, 2020 meeting by a roll call vote. (Motion carried 9-0-0)***

PUBLIC COMMENT

There were no requests for public comment

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO) provided a verbal update on the potential reductions in Medi-Cal expansion rates and noted that the Department of Health Care Services (DHCS) had notified CalOptima that the rate reduction would not be as large as originally anticipated. In addition, he noted that DHCS is also willing to work with CalOptima on the downward glide path. Mr. Sanchez told the committee that CalOptima had received from the Orange County Delegation on both the Federal and State levels recognition on CalOptima's 25th anniversary.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer provided an update on the on-going DHCS required Network Certification. She also discussed the Qualified Medicare Beneficiary (QMB) outreach to members who may qualify for both Medicare Part A and Part B. This would also identify members who could possibility qualify for either the OneCare or OneCare Connect programs.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer notified the committee that CalOptima had been awarded a quality award from DHCS. He noted that while it was not an award for OneCare Connect, it was indicative of the quality of care that CalOptima provides to all its members. He noted that CalOptima had met the minimum performance standard in all 40 required measures. CalOptima is the only plan in California to meet all 40 required measures.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Mouton notified the members that Erin Ulibarri the OC Office on Aging representative had resigned her seat as she had moved into another position within the Social Services Agency. She also reminded the members that their annual compliance courses were due by November 6, 2020. Chair Mouton formed an ad hoc committee comprised of herself, Meredith Chillemi and Gio Corzo to join the Member Advisory Committee and the Provider Advisory Committee to review the recruitment application as part of a joint ad hoc committee. She also notified the members that the next regular

OCC MAC meeting would be held on February 25, 2021 and reminded the committee members that the December meeting would be a joint meeting with the other Board Advisory Committees on December 10, 2020 in place of the regular OCC MAC meeting on December 17, 2020 which has been cancelled.

OneCare Connect Transition Planning

Ravina Hui, Director, Program Implementation notified the committee that the Centers for Medicare and Medi-Cal (CMS) had notified CalOptima that the Cal MediConnect program would end on December 1, 2022. She noted that existing OneCare Connect members would have the option of being moved to CalOptima's OneCare program.

Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs and Compliance, provided an update on various Federal and State Legislative items such as Assembly Bill (AB) 890 which would allow Nurse Practitioners to practice independently without the direct supervision of a physician and Senate Bill (SB) 275 which mandates that the State keep a minimum 45-day supply of personal protective equipment (PPE) on hand for emergencies. Mr. Roady also updated the members on the status of the Heroes Act.

OneCare Connect Benefit Changes for 2021

Andrew Tse, Manager, Customer Services presented on the OCC benefit changes for 2021. He noted that the Over the Counter (OTC) allowance had increased from $50 to $75 benefit allowance per quarter (every three months) to purchase OTC products and supplies available through the OTC mail-order catalog. He also noted that the fitness benefit included a membership to a contracted gym. Members may elect to receive up to two home fitness kits in addition to a gym membership. He also noted that the fitness benefit included an activity tracker for members.

ADJOURNMENT

Chair Mouton reminded the members that the next meeting was a joint meeting on December 10, 2020 at 8:00 a.m.

Hearing no further business, the meeting adjourned at 3:44 p.m.

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

Approved: March 11, 2021

Back to Agenda

MINUTES

SPECIAL JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE, PROVIDER ADVISORY COMMITTEE AND WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

December 10, 2020

A Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and Whole-Child Model Advisory Committee (WCM FAC) was held on Thursday, December 10, 2020 via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

PAC Chair Dr. Lazo-Pearson called the meeting to order at 8:05 a.m., and OCC MAC Chair Patty Mouton led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Christine Tolbert, Chair; Maura Byron; Sandy Finestone; Connie Gonzalez; Jacqueline Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Kate Polezhaev; Sr. Mary Terese Sweeney; Steve Thronson; Mallory Vega

Members Absent: Melisa Nicholson; Pamela Pimentel, Vice Chair

OneCare Connect Member Advisory Committee

Members Present: Patty Mouton, Chair; Meredith Chillemi; Gio Corzo; Josefina Diaz; Eleni Hailemariam, M.D. (non-voting); Sandy Finestone; Sara Lee; Mario Parada; Donald Stukes

Members Absent: Jyothi Atluri (non-voting); Keiko Gamez, Vice Chair; Donald Stukes

Provider Advisory Committee

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Alpesh Amin, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Tina Bloomer; Donald Bruhns, Dr. Inglis, Jena Jensen; John Kelly, M.D.; Teri Miranti; Alex Rossel; Loc Tran, Pharm.D.; Christy Ward

Members Absent: John Kelly, M.D.; Peter Korchin; Alexander Rossel

Back to Agenda

Whole-Child Model Family Advisory Committee

Members Present: Kristen Rogers, Chair; Brenda Deeley, Vice Chair; Maura Byron; Malissa Watson

Members Absent: Cathleen Collins; Sandra Cortez-Schultz; Jacque Knudsen; Kathleen Lear; Monica Maier
WCM FAC did not achieve a quorum.

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D., Interim Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Rachel Selleck, Executive Director, Public Affairs; Thanh-Tam Nguyen, M.D., Medical Director, Medical Management; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Praveena Lal, Administrative Assistant, Customer Service

PUBLIC COMMENT

There were no requests for public comment.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Chief Executive Officer, welcomed the members of the Board Advisory Committees. Mr. Sanchez reported that the Department of Health Care Services had postponed the Medi-Cal Rx program until April 1, 2021 and noted that it could be extended beyond that date. He also provided a brief update on the COVID pandemic and noted how the case counts were increasing but shared the good news on the availability of the new vaccine. Mr. Sanchez also introduced Rachel Selleck as the new Executive Director of Public Affairs.

Chief Medical Officer Update

Emily Fonda, M.D., Interim Chief Medical Officer gave a status update on COVID-19 for Orange County where the number of cases were still substantial. She discussed the significance of the vaccine and how important and necessary it is to prevent illness, deaths and any long term health consequences as experienced by many people. She shared that a high vaccine uptake at 70% or greater could help end the pandemic and noted that California is planning to distribute and administer vaccines as quicky as possible when the emergency use is finalized.

Back to Agenda

INFORMATION ITEMS

Trends in Early Diagnosis of Autism Spectrum Disorder

Jonathan T. Megerian M.D., Thompson Autism Center, Michael Weiss, M.D., CHOC Health Alliance and Charles Golden, M.D., CHOC presented on screening, diagnosis, and treatment trends in pediatric autism.

Trends in Adolescent Mental Health

Chelsea O'Haire, Director of Education & Training at The Center for Autism & Neurodevelopmental Disorders, UC Irvine, School of Medicine presented on trends in adolescent diagnoses of autism spectrum disorder as it continues to increase around the country.

Compassionate Care and Applied Behavior Analysis Treatment During the Pandemic

Junelyn Lazo-Pearson, Ph.D., Chief Clinical Officer, Advanced Behavioral Health presented on providing treatment specific to applied behavioral analysis during the pandemic.

Trauma Informed Care and Adverse Childhood Experiences (ACEs) Aware Update

Betsy Ha, Executive Director, Quality and Population Health Management presented and provided an update on ACES and trauma informed care framework and CalOptima's role in working with community partners to implement training, reimbursement while also addressing COVID-19 trauma related to the ACES.

COMMITTEE MEMBER UPDATES

MAC Chair Tolbert welcomed Jacqueline Gonzalez as the new Recipients of CalWORKs Representative and announced that the next regular MAC meeting was scheduled for February 11, 2021 at 2:30 PM. Chair Tolbert also reminded everyone on all the committees to please complete their compliance courses if they had not already done so.

OCC MAC Chair Mouton reminded the OCC MAC members that the next OCC MAC meeting was scheduled for February 25, 2021 at 3:00 PM. She also announced that there would be another special joint meeting on March 11, 2021 with a time to be determined.

PAC Chair Lazo-Pearson announced that the next PAC meeting was scheduled for February 11, 2021 at 8:00 AM. She also told the PAC that she would be reaching out to the members about presenting at various PAC meetings.

WCM FAC Chair Rogers announced that WCM FAC would hold their next regular meeting on February 23, 2021 at 9:30 AM.

Back to Agenda

ADJOURNMENT

There being no further business before the Committees WCM FAC Chair Kristen Rogers adjourned the meeting at 10:35 a.m.

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

Approved by Member Advisory Committee: February 11, 2021
Approved by OneCare Connect Member Advisory Committee: March 11, 2021
Approved by Provider Advisory Committee: February 11, 2021

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee increasing the size from three seats to four seats

Contact

Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Action

Recommend increasing the size of the CalOptima Board of Directors' Finance and Audit Committee from three seats to four seats.

Background/Discussion

On March 12, 1996, the Board of Directors established the Finance and Quality Assurance Committees, each consisting of three Board members appointed by the CalOptima Board Chair. The Finance Committee was charged with oversight responsibilities for all financial matters affecting CalOptima. In November 2009, the Board changed the Finance Committee title to the Board of Directors' Finance and Audit Committee (FAC) and expanded the scope of responsibilities to include audit oversight. In April 2010, the Board expanded the size of the FAC to four Board members. Based on composition and size, in August 2016, the Board reduced the size of the FAC from four to three Board seats.

Now with the current makeup of the Board of Directors and board member expertise, it is recommended that the size of the FAC be increased from three seats to four seats. All four seats are to be occupied by members of the CalOptima Board of Directors.

Fiscal Impact

None

Rationale for Recommendation

The recommended action is to add one additional seat to the Finance and Audit Committee in alignment with the current Board size and membership.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Sanchez *03/24/2021*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Modifications to CalOptima Pharmacy Management Policies and Procedures in connection with CalOptima's regular review process and consistent with regulatory requirements to Policies MA.6106 Medication Therapy Management [OneCare, OneCare Connect] and GG.1401 Pharmacy Authorization Process [Medi-Cal]

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Kris Gericke, Pharm.D., Director, Clinical Pharmacy Management (714) 246-8460

Recommended Action

Authorize modifications to the following existing policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements:

1. MA.6106 Medication Therapy Management [OneCare, OneCare Connect]
2. GG.1401 Pharmacy Authorization Process [Medi-Cal]

Background/ Discussion

CalOptima staff regularly reviews agency Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, and laws, as well as CalOptima operations.

Below is information regarding recommended policy modifications:

MA.6106 Medication Therapy Management [OneCare, OneCare Connect]: This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) processes and standards. Updates included revising cost thresholds as required in "CY 2021 Medication Therapy Management Program Guidance and Submission Instructions" and updating the MTM vendor policy name pertaining to the prescriber fax process.

GG.1401 Pharmacy Authorization Process [Medi-Cal]: This policy defines the process by which CalOptima addresses and resolves Prior Authorization requests for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements. CalOptima staff recommends revising this policy pursuant to the annual review process to ensure alignment with current operations and regulatory requirements, including updating the response time to pharmacy authorization requests. Because of the delay by DHCS of the transition to Medi-Cal Rx, updating this policy is necessary for continued compliance during this delay.

Fiscal Impact

The recommended action to authorize the CEO to revise CalOptima Policies MA.6106 and GG.1401 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Back to Agenda

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior version.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. MA.6106 Medication Therapy Management [OneCare, OneCare Connect]
2. GG.1401 Pharmacy Authorization Process [Medi-Cal]

/s/ Richard Sanchez — *03/24/2021*

Authorized Signature — **Date**

Back to Agenda

Policy:	MA.6106
Title:	**Medication Therapy Management**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/2006
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) MTM processes and standards.

II. POLICY

A. On an annual basis, CalOptima shall develop an MTM program in cooperation with licensed and practicing Pharmacists and Providers.

B. CalOptima shall submit the MTM program description annually to CMS for review and approval during the appropriate MTM program submission window.

C. The MTM program includes elements to:

1. Promote and enhance Member understanding of the appropriate use of medications to optimize therapeutic outcomes.

2. Reduce the risk of potential adverse events, including adverse drug interactions, associated with medications through Member education, counseling, and other appropriate means.

3. Increase Member Medication Adherence with medication refill reminders, special packaging, and other case specific aids that will improve Members drug adherence.

4. Detect adverse drug events and patterns of medication utilization. This will include, but not be limited to overutilization, underutilization, suboptimal dosing, appropriateness of therapy, medications without a clear indication, identifying side effects related to drug therapy, polypharmacy, drug-drug interactions, drug-food interactions, and drug-disease interactions.

5. Coordinate with CalOptima's care management plan established for a targeted individual under a chronic care improvement program (CCIP).

D. CalOptima identifies Members eligible for the MTM program and shall provide MTM program services, in accordance with the provisions of this Policy.

E. CalOptima safeguards against discrimination based on the nature of MTM interventions (i.e., TTY if phone based, Braille if mail based, etc.).

F. CalOptima does not deny a Member's access to prescription drugs based on the Member's failure to participate in the MTM program.

G. CalOptima uses the MTM program to detect, evaluate, and resolve medication issues to ensure cost-effective medication use and the highest quality clinical outcomes for Members.

H. CalOptima reimburses Qualified Providers participating in the MTM program in accordance with the current program year's fee schedule. CalOptima lists the reimbursement rates in the annual CMS MTM program submission.

I. Upon request, CalOptima shall disclose to CMS the amount of the management and dispensing fees, and the portion paid for the MTM program services to CMS approved Qualified Providers. Such reports are protected under the provisions of Section 1927(b)(3)(D) of the Social Security Act.

J. The MTM program may distinguish between services in ambulatory and institutional settings. Where in institutional settings, the Comprehensive Medication Review (CMR) Provider may choose to meet the patient or caregiver at the Member's facility or complete the review telephonically.

~~J.~~K. CalOptima enrolls a Targeted Beneficiary using an opt-out method of enrollment only, as provided in this Policy.

~~K.A. CalOptima enrolls a Targeted Beneficiary using an opt-out method of enrollment only. CalOptima shall auto-enroll the Targeted Beneficiary each contract year when he or she meets the eligibility criteria, and he or she is considered enrolled, unless the Member declines enrollment or requests to be disenrolled by the opt-out methodology. CalOptima's presumption is the Member opts-out for the applicable contract year unless the Member explicitly states the opt-out is permanent or requests not to be contacted again regarding MTM.~~

~~1. A Member enrolled in CalOptima's MTM program may refuse or decline services without having to disenroll from the MTM program.~~

~~2.1. Should an identified Member desire to permanently opt-out of the MTM program, CalOptima honors the request and does not re-target the Member in future contract years.~~

~~a. If the Member actively seeks enrollment in the MTM program at a later time, CalOptima allows the Member to participate as long as he or she meets the necessary MTM requirements.~~

~~L.A. Opt-outs shall be recorded by CalOptima Pharmacy Staff or local Pharmacists as follows:~~

~~1. Opt-outs due to plan disenrollment will be documented with an opt-out date corresponding to the last date of plan eligibility.~~

~~2.1. Opt-out dates due to death will be documented with an opt-out date corresponding to the last date of plan eligibility in accordance with CMS PCUG Guidance, Chapter 2, 50.2.3.~~

~~3.1. Member-level opt-out requests shall be documented as the receipt date of the Member's written notification or date of the verbal request. If a verbal request is received by CalOptima's Customer Service Department, it shall be documented in the Customer Service call logging system and the Pharmacy Department notified of the opt-out.~~

~~M.~~L. CalOptima targets Members for enrollment in the MTM program at least quarterly during each year according to the CMS approved MTM program methodology.

~~N.~~M. CalOptima offers a CMR to all Members enrolled in the MTM Program at least annually, and this includes Members who are in a Long-Term Care (LTC) setting.

~~O.~~N. CalOptima's MTM services are furnished by a Pharmacist or other Qualified Provider.

~~P.~~O. CalOptima shall not make any positive or negative changes to the approved MTM program within a given contract year without first receiving approval by CMS.

~~Q.A. All MTM documentation is subject to the record retention requirements outlined in the Medicare Managed Care Manual Chapter 11: 100.4.~~

III. PROCEDURE

A. Member Identification and Targeting

1. Targeted Beneficiaries. CalOptima identifies Members eligible for enrollment in the MTM program based on the following criteria:

   a. Member is receiving Part D medications to treat three (3) or more of the following core chronic conditions:

      i. Diabetes;

      ii. Respiratory Disease-Asthma;

      iii. Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD);

      iv. Hypertension;

      v. Dyslipidemia; or

      vi. End Stage Renal Disease (ESRD).

   b. Member is receiving eight (8) or more Part D medications per quarter; and

   c. Member is likely to incur annual costs for Covered Part D Drugs that exceed a dollar threshold prescribed by CMS; for CY 202~~1~~0 the threshold is $4,376~~255~~.00.

      i. CalOptima calculates the total pharmacy claims for a Member on a quarterly basis.

      ii. CalOptima considers a Member as likely to incur an annual cost of $4,~~255~~376.00 if the Member has $1,094.00~~63.75~~ or more in paid claims for the quarter being evaluated.

2. On a quarterly basis, CalOptima's Pharmacy Management Department identifies Members who meet the criteria for inclusion in the MTM program through pharmacy and medical claims data. Medical claims analysis is limited to specific disease states as determined appropriate by CalOptima Pharmacy Department.

   a. Current disease states supported by a combination of medical claims or pharmacy

claims: End Stage Renal Disease.

b. Expanded Internal Eligibility Criteria. MTM services are also offered to Members who meet Expanded Internal Eligibility Criteria based on the Part D Drug Management Program for high-risk beneficiaries. Identified Members receive the same CMRs, TMRs, and interventions that Members who meet the specified criteria per CMS requirements receive. All aspects of the MTM program apply to this population.

i. Members are identified for the Drug Management Program at minimum quarterly utilizing the minimum Overutilization Monitoring System (OMS) criteria for calendar year 2020:

a. A look back period of the previous six (6) months; and

b. Member prescription exceeded an average daily morphine milligram equivalent (MME) of ninety (90) milligrams (mg) for any duration; and

i. Filled prescriptions written by three (3) or more Opioid prescribers and at three (3) or more pharmacies; or

ii. Filled prescriptions written by five (5) or more Opioid prescribers, regardless of the number of Opioid dispensing pharmacies.

ii. Members excluded from the Drug Management Program, who will therefore not be identified for MTM based on Drug Management Program involvement, shall include:

a. Members being treated for active cancer-related pain;

b. Members receiving hospice, palliative, or end-of-life care;

c. Members residing in a long-term care facility, a facility described in section 1905(d) of the Act, or another facility for which frequently Abused drugs are dispensed for residents through a contract with a single pharmacy.

3. CalOptima notifies a Member who qualifies for the MTM program by sending an MTM invitation letter via United States (U.S.) mail.

a. Qualified Members are auto enrolled into the CalOptima MTM program and will remain enrolled through the contract year unless the Member opts out of the MTM program entirely.

b. Qualified Members may opt-out from all or parts of the MTM program (TMR, CMR).

c. In addition to invitation letters, CalOptima conducts phone outreaches to qualified Members to increase CMR participation as a second approach to offer MTM services.

4. CalOptima shall auto-enroll the Targeted Beneficiary each contract year when he or she meets the eligibility criteria, and he or she is considered enrolled, unless the Member declines enrollment or requests to be disenrolled by the opt-out methodology. CalOptima's presumption is the Member opts out for the applicable contract year unless the Member explicitly states the opt-out is permanent or requests not to be contacted again regarding MTM.

a. A Member enrolled in CalOptima's MTM program may refuse or decline services without having to disenroll from the MTM program.

b. Should an identified Member desire to permanently opt-out of the MTM program, CalOptima honors the request and does not re-target the Member in future contract years.

i. If the Member actively seeks enrollment in the MTM program at a later time, CalOptima allows the Member to participate as long as he or she meets the necessary MTM requirements.

5. Opt-outs shall be recorded by CalOptima Pharmacy Staff or local Pharmacists as follows:

a. Opt-outs due to plan disenrollment will be documented with an opt-out date corresponding to the last date of plan eligibility.

b. Opt-out dates due to death will be documented with an opt-out date corresponding to the last date of plan eligibility in accordance with CMS PCUG Guidance, Chapter 2, 50.2.3.

c. Member-level opt-out requests shall be documented as the receipt date of the Member's written notification or date of the verbal request. If a verbal request is received by CalOptima's Customer Service Department, it shall be documented in the Customer Service call logging system and the Pharmacy Department notified of the opt-out.

B. Services provided in the MTM program include, but are not limited to:

1. Offering a face-to-face or telephonic CMR at least annually by a Qualified Provider as indicated in the current year's MTM program submission to CMS. CMRs will include an interactive and comprehensive review of a Member's over-the-counter (OTC) medications, vitamin/herbal/dietary supplements, and prescription medications. Qualified Providers shall provide a summary of the results of the CMR to the Member in CMS' standardized format within fourteen (14) calendar days of the completed CMR.

a. When the CMR is performed by CalOptima staff or local Pharmacists, CalOptima will print and mail the CMR documents in accordance with the Facilities Department mailroom procedure and CalOptima policy, as appropriate.

b. CalOptima offers the CMR to newly targeted Members within sixty (60) calendar days after being enrolled in the MTM program.

c. For Members enrolled in MTM the previous contract year who continue to meet criteria in the current contract year, the CMR is offered within one (1) year (i.e., 365 days) of the last CMR offer.

d. If the Member is offered the annual CMR and is unable to accept the offer to participate, the Pharmacist or other Qualified Provider as defined in the current contract year's CMS-approved MTM program may perform the CMR with the Member's prescriber, caregiver or other authorized individual.

e. For cognitively impaired Members, CalOptima reaches out to the Member's prescriber, caregiver or other authorized individual to complete the CMR. This applies to Members in all settings, including LTC.

i. CalOptima's Pharmacy Management Department collects documentation and/or will provide rationale when making the determination that a Member is cognitively impaired and unable to participate in the CMR.

f. CalOptima recognizes the challenges of performing CMRs in the LTC setting and engages Qualified Providers to perform the CMR who have experience engaging Members, prescribers and ancillary health care professionals in the LTC setting.

i. Where possible, CalOptima coordinates MTM activities with the care plan meeting to assess current regimens.

2. Formulation of a Medication Action Plan (MAP);

3. Formulation of a Personal Medication List (PML);

4. Evaluation and monitoring of a Member's response to drug therapy;

5. Coordination of medication therapy with other care management services, such as case management; and

6. Performing quarterly TMRs. TMRs systematically look for drug therapy issues. CalOptima's MTM vendor provides outreach to prescribers via fax in accordance with the methodologies outlined in MTM vendor's policy, ~~CLOP_044~~CSSHealth Operations Support Policy and Procedure Manual, as referenced herein. Educational newsletters are mailed to Members who are in the program. Also, follow-up interventions will be provided, if necessary, for all Members enrolled in the MTM program.

a. If a Member declines the annual CMR, CalOptima still offers interventions to the prescriber and performs TMRs at least quarterly to assess medication use on an on-going basis.

b. CalOptima performs TMR interventions to the beneficiary's prescribers irrespective of the CMR acceptance or completion.

7. On a quarterly basis, CalOptima's Pharmacy Management Department shall:

a. Notify a Member's Primary Care Provider (PCP) of the Member's participation in the MTM program to ensure coordination between the MTM program and the care provided by the PCP; and

b. Provide a list of Members participating in the MTM program to the CalOptima Case Management Department to ensure coordination between the MTM program and the Medicare chronic care improvement program (CCIP) under Section 1807 of the Social Security Act.

C. While offering the CMR, the Qualified Provider shall:

1. Review the Member's medication profile with respect to:

a. Therapeutic duplication;

b. Appropriateness of therapy, including medically accepted indications (MAI);

c. Appropriateness of dosing;

d. Drug to drug interactions;

e. Drug to disease interactions;

f. Contraindications;

g. Adverse effects;

h. Subtherapeutic response; and

i. Overutilization as evidenced by:

i. Controlled substances, especially opiates;

ii. Excessive quantities; or

iii. High doses.

2. Underutilization as evidenced by:

a. Poor adherence; or

b. Subtherapeutic dose.

3. Potential Fraud and Abuse;

4. Multiple prescribers; and

5. Other parameters as determined by the Qualified Provider on a case-by-case basis.

a. Provide individual education to the Member regarding appropriate medication use;

b. Utilize interventions to improve adherence to prescribed medication regimens, such as directed counseling, special packaging, or refill reminders; and

c. Contact the Member's Prescriber, as necessary, to recommend changes to the medication regimen.

D. Billing for local Pharmacist and LTC Pharmacist provided MTM services shall be done using MTM Current Procedural Terminology (CPT) codes appropriate for the type and length of service provided. MTM CPT codes are listed in the following table:

MTM CPT Codes

CPT Code	Description	Reimbursement Rate
99605	MTM service(s) provided by a Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an initial encounter with a new MTM patient	$25

CPT Code	Description	Reimbursement Rate
99606	MTM service(s) provided by a Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an encounter with ~~Initial fifteen (15) minutes with~~ an established patient	$25
99607	Each additional fifteen (15) minutes of an initial or subsequent MTM encounter; list separately in addition to code for primary service and in conjunction with 99605 or 99606	$25

E. CalOptima's Pharmacy Management Department shall measure the effectiveness of the MTM program through:

1. High risk medication utilization;
2. The number of physician-accepted drug therapy recommendations;
3. Annual pharmacy expenditures per Member;
4. Member satisfaction surveys; and
5. The number of drug therapy resolutions other than physician-accepted recommendations, such as medication adherence.

F. CalOptima shall report to CMS specific data on the MTM program in the manner prescribed by CMS. CalOptima shall report information annually related to the implementation of the MTM program that may include, but is not limited to:

1. Number of Members identified for the MTM program;
2. Number of Members participating in the MTM program;
3. Number of Members who are eligible, but declined participation in the MTM program; and

~~4.~~6. Total drug cost for Members in MTM on a per MTM-enrolled Member per month basis.

G. CalOptima increases Member awareness about the MTM program and promotes its value by ensuring Customer Service representatives and staff are trained and familiar with the MTM program.

1. CalOptima loads MTM eligibility into the Customer Service call system which provides eligibility information to Customer Service representatives.

H. CalOptima also includes a separate section on MTM on their website that includes:

1. CalOptima's specific MTM program eligibility requirements;
2. A statement informing Members who to contact at CalOptima for more information, with customer service personnel prepared to answer questions about the MTM program;
3. High-level summary of services offered as part of the MTM program;

4. A statement explaining the purpose and benefits of MTM, and that it is a free service for eligible Members;

5. A description of how the Member will be notified by CalOptima that they are eligible and enrolled in the MTM program;

6. Statements on how Members will be contacted and offered services by CalOptima, including the CMR and TMR, and a description of how the reviews are conducted and delivered, including time commitments and materials Members will receive;

7. A statement on how the Member may obtain MTM service documents, including a blank copy of the Personal Medication List posted on the website; and

8. A statement clarifying that the MTM Program is not considered a benefit.

I. All MTM documentation is subject to the record retention requirements outlined in the Medicare Managed Care Manual Chapter 11: 100.4.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CMS Prescription Drug Benefit Manual, Chapter 7 – Medication Therapy Management and Quality Improvement Program, Revised 02/19/2010
E. "CY 2021~~0~~ Medication Therapy Management Program ~~Guidance~~ Information and Submission Instructions," Health Plan Management System (HPMS) Memorandum, Issued ~~04/05/2019~~05/22/2020
F. CMS PCUG Guidance, Chapter 2, 50.2.3
G. Medicare Managed Care Manual Chapter 11: 100.4
H. Medicare Modernization Act, Section 1860D-4(c)(2)
I. Pharmacy Services Program Manual "Revisions to the Medicare Part D Medication Therapy Management Program Standardized Format." Health Plan Management System (HPMS) Memorandum, Issued 08/29/2017
J. California Business and Professions Code, §4040
K. Social Security Act, §1807
L. Title 42, Code of Federal Regulations (CFR), §423.153(d)(e)
M. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019
N. MTM Vendor
   a. CSSHealth Operations Support Policy and Procedure Manual~~Provider Faxing Policy #CLOP_044~~

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2008	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2011	MA.6106	Medication Therapy Management	OneCare
Revised	01/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	05/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	10/01/2014	MA.6106	Medication Therapy Management	OneCare
Revised	06/01/2015	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	07/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	12/01/2017	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	02/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	10/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	08/06/2020	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	TBD	MA.6106	Medication Therapy Management	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare program. OneCare Connect: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare Connect program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare Connect program. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Comprehensive Medication Review (CMR)	A process of collecting Member-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the Member, caregiver and/or prescriber. It is designed to improve Member's knowledge of their prescriptions, OTC medications, identify and address problems or concerns the Member may have, and empower Members to self-manage their medications and health conditions.
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Expanded Internal Eligibility Criteria	Additional criteria selected and determined by the plan. All MTM services offered to enrollees who meet the specified targeting criteria per CMS requirements must also be offered to those meeting the expanded internal eligibility criteria.

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit_to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i)~~.~~
Long Term Care	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Medication Adherence	The extent to which a person takes medications as prescribed by their health care Providers.
Medication Therapy Management (MTM)	A program of drug therapy management furnished by a Pharmacist and that is designed to: 1. Assure that Covered Part D Drugs are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions.
Member	A beneficiary enrolled in a CalOptima program.
Over-the Counter (OTC)	Defined as products available for purchase without a prescription.
Pharmacist	A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy.
Primary Care Provider (PCP)	OneCare: A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare. OneCare Connect: A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a Primary Care P~~p~~hysician or N~~n~~on-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.~~
Qualified Provider	An individual who completes the Interactive, person-to-person Comprehensive Medication Review (CMR) with written summaries as defined in the current MTM Program approved by CMS.
Targeted Beneficiary	A CalOptima Member who meets the eligibility criteria of the MTM program, which includes having at least three (3) qualifying core chronic diseases, is taking eight (8) or more Part D medications per quarter, and one who is likely to incur annual costs for Covered Part D Drugs greater than or equal to the MTM annual cost threshold as further identified in this Policy.
Targeted Medication Review (TMR)	A review focused on specific or potential medication-related problems. The identified problem is communicated directly to the Member's prescriber.

Policy:	MA.6106
Title:	**Medication Therapy Management**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/2006
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) MTM processes and standards.

II. POLICY

A. On an annual basis, CalOptima shall develop an MTM program in cooperation with licensed and practicing Pharmacists and Providers.

B. CalOptima shall submit the MTM program description annually to CMS for review and approval during the appropriate MTM program submission window.

C. The MTM program includes elements to:

1. Promote and enhance Member understanding of the appropriate use of medications to optimize therapeutic outcomes.

2. Reduce the risk of potential adverse events, including adverse drug interactions, associated with medications through Member education, counseling, and other appropriate means.

3. Increase Member Medication Adherence with medication refill reminders, special packaging, and other case specific aids that will improve Members drug adherence.

4. Detect adverse drug events and patterns of medication utilization. This will include, but not be limited to overutilization, underutilization, suboptimal dosing, appropriateness of therapy, medications without a clear indication, identifying side effects related to drug therapy, polypharmacy, drug-drug interactions, drug-food interactions, and drug-disease interactions.

5. Coordinate with CalOptima's care management plan established for a targeted individual under a chronic care improvement program (CCIP).

D. CalOptima identifies Members eligible for the MTM program and shall provide MTM program services, in accordance with the provisions of this Policy.

E. CalOptima safeguards against discrimination based on the nature of MTM interventions (i.e., TTY if phone based, Braille if mail based, etc.).

F. CalOptima does not deny a Member's access to prescription drugs based on the Member's failure to participate in the MTM program.

G. CalOptima uses the MTM program to detect, evaluate, and resolve medication issues to ensure cost-effective medication use and the highest quality clinical outcomes for Members.

H. CalOptima reimburses Qualified Providers participating in the MTM program in accordance with the current program year's fee schedule. CalOptima lists the reimbursement rates in the annual CMS MTM program submission.

I. Upon request, CalOptima shall disclose to CMS the amount of the management and dispensing fees, and the portion paid for the MTM program services to CMS approved Qualified Providers. Such reports are protected under the provisions of Section 1927(b)(3)(D) of the Social Security Act.

J. The MTM program may distinguish between services in ambulatory and institutional settings. Where in institutional settings, the Comprehensive Medication Review (CMR) Provider may choose to meet the patient or caregiver at the Member's facility or complete the review telephonically.

K. CalOptima enrolls a Targeted Beneficiary using an opt-out method of enrollment only, as provided in this Policy.

L. CalOptima targets Members for enrollment in the MTM program at least quarterly during each year according to the CMS approved MTM program methodology.

M. CalOptima offers a CMR to all Members enrolled in the MTM Program at least annually, and this includes Members who are in a Long-Term Care (LTC) setting.

N. CalOptima's MTM services are furnished by a Pharmacist or other Qualified Provider.

O. CalOptima shall not make any positive or negative changes to the approved MTM program within a given contract year without first receiving approval by CMS.

III. PROCEDURE

A. Member Identification and Targeting

1. Targeted Beneficiaries. CalOptima identifies Members eligible for enrollment in the MTM program based on the following criteria:

a. Member is receiving Part D medications to treat three (3) or more of the following core chronic conditions:

i. Diabetes;

ii. Respiratory Disease-Asthma;

iii. Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD);

iv. Hypertension;

v. Dyslipidemia; or

vi. End Stage Renal Disease (ESRD).

b. Member is receiving eight (8) or more Part D medications per quarter; and

c. Member is likely to incur annual costs for Covered Part D Drugs that exceed a dollar threshold prescribed by CMS; for CY 2021 the threshold is $4,376.00.

i. CalOptima calculates the total pharmacy claims for a Member on a quarterly basis.

ii. CalOptima considers a Member as likely to incur an annual cost of $4,376.00 if the Member has $1,094.00 or more in paid claims for the quarter being evaluated.

2. On a quarterly basis, CalOptima's Pharmacy Management Department identifies Members who meet the criteria for inclusion in the MTM program through pharmacy and medical claims data. Medical claims analysis is limited to specific disease states as determined appropriate by CalOptima Pharmacy Department.

a. Current disease states supported by a combination of medical claims or pharmacy claims: End Stage Renal Disease.

b. Expanded Internal Eligibility Criteria. MTM services are also offered to Members who meet Expanded Internal Eligibility Criteria based on the Part D Drug Management Program for high-risk beneficiaries. Identified Members receive the same CMRs, TMRs, and interventions that Members who meet the specified criteria per CMS requirements receive. All aspects of the MTM program apply to this population.

i. Members are identified for the Drug Management Program at minimum quarterly utilizing the minimum Overutilization Monitoring System (OMS) criteria for calendar year 2020:

a. A look back period of the previous six (6) months; and

b. Member prescription exceeded an average daily morphine milligram equivalent (MME) of ninety (90) milligrams (mg) for any duration; and

i. Filled prescriptions written by three (3) or more Opioid prescribers and at three (3) or more pharmacies; or

ii. Filled prescriptions written by five (5) or more Opioid prescribers, regardless of the number of Opioid dispensing pharmacies.

ii. Members excluded from the Drug Management Program, who will therefore not be identified for MTM based on Drug Management Program involvement, shall include:

a. Members being treated for active cancer-related pain;

b. Members receiving hospice, palliative, or end-of-life care;

c. Members residing in a long-term care facility, a facility described in section

1905(d) of the Act, or another facility for which frequently Abused drugs are dispensed for residents through a contract with a single pharmacy.

3. CalOptima notifies a Member who qualifies for the MTM program by sending an MTM invitation letter via United States (U.S.) mail.

   a. Qualified Members are auto enrolled into the CalOptima MTM program and will remain enrolled through the contract year unless the Member opts out of the MTM program entirely.

   b. Qualified Members may opt-out from all or parts of the MTM program (TMR, CMR).

   c. In addition to invitation letters, CalOptima conducts phone outreaches to qualified Members to increase CMR participation as a second approach to offer MTM services.

4. CalOptima shall auto-enroll the Targeted Beneficiary each contract year when he or she meets the eligibility criteria, and he or she is considered enrolled, unless the Member declines enrollment or requests to be disenrolled by the opt-out methodology. CalOptima's presumption is the Member opts out for the applicable contract year unless the Member explicitly states the opt-out is permanent or requests not to be contacted again regarding MTM.

   a. A Member enrolled in CalOptima's MTM program may refuse or decline services without having to disenroll from the MTM program.

   b. Should an identified Member desire to permanently opt-out of the MTM program, CalOptima honors the request and does not re-target the Member in future contract years.

      i. If the Member actively seeks enrollment in the MTM program at a later time, CalOptima allows the Member to participate as long as he or she meets the necessary MTM requirements.

5. Opt-outs shall be recorded by CalOptima Pharmacy Staff or local Pharmacists as follows:

   a. Opt-outs due to plan disenrollment will be documented with an opt-out date corresponding to the last date of plan eligibility.

   b. Opt-out dates due to death will be documented with an opt-out date corresponding to the last date of plan eligibility in accordance with CMS PCUG Guidance, Chapter 2, 50.2.3.

   c. Member-level opt-out requests shall be documented as the receipt date of the Member's written notification or date of the verbal request. If a verbal request is received by CalOptima's Customer Service Department, it shall be documented in the Customer Service call logging system and the Pharmacy Department notified of the opt-out.

B. Services provided in the MTM program include, but are not limited to:

1. Offering a face-to-face or telephonic CMR at least annually by a Qualified Provider as indicated in the current year's MTM program submission to CMS. CMRs will include an interactive and comprehensive review of a Member's over-the-counter (OTC) medications, vitamin/herbal/dietary supplements, and prescription medications. Qualified Providers shall provide a summary of the results of the CMR to the Member in CMS' standardized format within fourteen (14) calendar days of the completed CMR.

a. When the CMR is performed by CalOptima staff or local Pharmacists, CalOptima will print and mail the CMR documents in accordance with the Facilities Department mailroom procedure and CalOptima policy, as appropriate.

b. CalOptima offers the CMR to newly targeted Members within sixty (60) calendar days after being enrolled in the MTM program.

c. For Members enrolled in MTM the previous contract year who continue to meet criteria in the current contract year, the CMR is offered within one (1) year (i.e., 365 days) of the last CMR offer.

d. If the Member is offered the annual CMR and is unable to accept the offer to participate, the Pharmacist or other Qualified Provider as defined in the current contract year's CMS-approved MTM program may perform the CMR with the Member's prescriber, caregiver or other authorized individual.

e. For cognitively impaired Members, CalOptima reaches out to the Member's prescriber, caregiver or other authorized individual to complete the CMR. This applies to Members in all settings, including LTC.

   i. CalOptima's Pharmacy Management Department collects documentation and/or will provide rationale when making the determination that a Member is cognitively impaired and unable to participate in the CMR.

f. CalOptima recognizes the challenges of performing CMRs in the LTC setting and engages Qualified Providers to perform the CMR who have experience engaging Members, prescribers and ancillary health care professionals in the LTC setting.

   i. Where possible, CalOptima coordinates MTM activities with the care plan meeting to assess current regimens.

2. Formulation of a Medication Action Plan (MAP);

3. Formulation of a Personal Medication List (PML);

4. Evaluation and monitoring of a Member's response to drug therapy;

5. Coordination of medication therapy with other care management services, such as case management; and

6. Performing quarterly TMRs. TMRs systematically look for drug therapy issues. CalOptima's MTM vendor provides outreach to prescribers via fax in accordance with the methodologies outlined in MTM vendor's policy, CSSHealth Operations Support Policy and Procedure Manual, as referenced herein. Educational newsletters are mailed to Members who are in the program. Also, follow-up interventions will be provided, if necessary, for all Members enrolled in the MTM program.

   a. If a Member declines the annual CMR, CalOptima still offers interventions to the prescriber and performs TMRs at least quarterly to assess medication use on an on-going basis.

   b. CalOptima performs TMR interventions to the beneficiary's prescribers irrespective of the CMR acceptance or completion.

7. On a quarterly basis, CalOptima's Pharmacy Management Department shall:

    a. Notify a Member's Primary Care Provider (PCP) of the Member's participation in the MTM program to ensure coordination between the MTM program and the care provided by the PCP; and

    b. Provide a list of Members participating in the MTM program to the CalOptima Case Management Department to ensure coordination between the MTM program and the Medicare chronic care improvement program (CCIP) under Section 1807 of the Social Security Act.

C. While offering the CMR, the Qualified Provider shall:

1. Review the Member's medication profile with respect to:

    a. Therapeutic duplication;

    b. Appropriateness of therapy, including medically accepted indications (MAI);

    c. Appropriateness of dosing;

    d. Drug to drug interactions;

    e. Drug to disease interactions;

    f. Contraindications;

    g. Adverse effects;

    h. Subtherapeutic response; and

    i. Overutilization as evidenced by:

        i. Controlled substances, especially opiates;

        ii. Excessive quantities; or

        iii. High doses.

2. Underutilization as evidenced by:

    a. Poor adherence; or

    b. Subtherapeutic dose.

3. Potential Fraud and Abuse;

4. Multiple prescribers; and

5. Other parameters as determined by the Qualified Provider on a case-by-case basis.

    a. Provide individual education to the Member regarding appropriate medication use;

b. Utilize interventions to improve adherence to prescribed medication regimens, such as directed counseling, special packaging, or refill reminders; and

c. Contact the Member's Prescriber, as necessary, to recommend changes to the medication regimen.

D. Billing for local Pharmacist and LTC Pharmacist provided MTM services shall be done using MTM Current Procedural Terminology (CPT) codes appropriate for the type and length of service provided. MTM CPT codes are listed in the following table:

MTM CPT Codes

CPT Code	Description	Reimbursement Rate
99605	MTM service(s) provided by a Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an initial encounter with a new MTM patient	$25
99606	MTM service(s) provided by a Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an encounter with an established patient	$25
99607	Each additional fifteen (15) minutes of an initial or subsequent MTM encounter; list separately in addition to code for primary service and in conjunction with 99605 or 99606	$25

E. CalOptima's Pharmacy Management Department shall measure the effectiveness of the MTM program through:

1. High risk medication utilization;

2. The number of physician-accepted drug therapy recommendations;

3. Annual pharmacy expenditures per Member;

4. Member satisfaction surveys; and

5. The number of drug therapy resolutions other than physician-accepted recommendations, such as medication adherence.

F. CalOptima shall report to CMS specific data on the MTM program in the manner prescribed by CMS. CalOptima shall report information annually related to the implementation of the MTM program that may include, but is not limited to:

1. Number of Members identified for the MTM program;

2. Number of Members participating in the MTM program;

3. Number of Members who are eligible, but declined participation in the MTM program; and

6. Total drug cost for Members in MTM on a per MTM-enrolled Member per month basis.

G. CalOptima increases Member awareness about the MTM program and promotes its value by ensuring Customer Service representatives and staff are trained and familiar with the MTM program.

1. CalOptima loads MTM eligibility into the Customer Service call system which provides eligibility information to Customer Service representatives.

H. CalOptima also includes a separate section on MTM on their website that includes:

1. CalOptima's specific MTM program eligibility requirements;

2. A statement informing Members who to contact at CalOptima for more information, with customer service personnel prepared to answer questions about the MTM program;

3. High-level summary of services offered as part of the MTM program;

4. A statement explaining the purpose and benefits of MTM, and that it is a free service for eligible Members;

5. A description of how the Member will be notified by CalOptima that they are eligible and enrolled in the MTM program;

6. Statements on how Members will be contacted and offered services by CalOptima, including the CMR and TMR, and a description of how the reviews are conducted and delivered, including time commitments and materials Members will receive;

7. A statement on how the Member may obtain MTM service documents, including a blank copy of the Personal Medication List posted on the website; and

8. A statement clarifying that the MTM Program is not considered a benefit.

I. All MTM documentation is subject to the record retention requirements outlined in the Medicare Managed Care Manual Chapter 11: 100.4.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CMS Prescription Drug Benefit Manual, Chapter 7 – Medication Therapy Management and Quality Improvement Program, Revised 02/19/2010
E. "CY 2021 Medication Therapy Management Program Information and Submission Instructions," Health Plan Management System (HPMS) Memorandum, Issued 05/22/2020
F. CMS PCUG Guidance, Chapter 2, 50.2.3

G. Medicare Managed Care Manual Chapter 11: 100.4
H. Medicare Modernization Act, Section 1860D-4(c)(2)
I. Pharmacy Services Program Manual "Revisions to the Medicare Part D Medication Therapy Management Program Standardized Format." Health Plan Management System (HPMS) Memorandum, Issued 08/29/2017
J. California Business and Professions Code, §4040
K. Social Security Act, §1807
L. Title 42, Code of Federal Regulations (CFR), §423.153(d)(e)
M. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019
N. MTM Vendor
   a. CSSHealth Operations Support Policy and Procedure Manual

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2008	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2011	MA.6106	Medication Therapy Management	OneCare
Revised	01/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	05/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	10/01/2014	MA.6106	Medication Therapy Management	OneCare
Revised	06/01/2015	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	07/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	12/01/2017	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	02/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	10/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	08/06/2020	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	TBD	MA.6106	Medication Therapy Management	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare program. OneCare Connect: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare Connect program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare Connect program. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
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End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
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Term	Definition
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Primary Care Provider (PCP)	OneCare: A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare. OneCare Connect: A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Qualified Provider	An individual who completes the Interactive, person-to-person Comprehensive Medication Review (CMR) with written summaries as defined in the current MTM Program approved by CMS.
Targeted Beneficiary	A CalOptima Member who meets the eligibility criteria of the MTM program, which includes having at least three (3) qualifying core chronic diseases, is taking eight (8) or more Part D medications per quarter, and one who is likely to incur annual costs for Covered Part D Drugs greater than or equal to the MTM annual cost threshold as further identified in this Policy.
Targeted Medication Review (TMR)	A review focused on specific or potential medication-related problems. The identified problem is communicated directly to the Member's prescriber.

Policy:	GG.1401
Title:	**Pharmacy Authorization Process**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Pharmacy ~~prior authorization~~Prior Authorization (PA) process.

II. POLICY

A. CalOptima shall require a ~~prior authorization~~Prior Authorization for medications and supplies that:

1. Are not listed on the closed ~~formulary~~Formulary, also known as the Approved Drug List;

2. Are on the ~~formulary~~Formulary but exceed ~~formulary~~Formulary limitations for quantity, refill frequency, or duration of therapy;

3. Do not meet on-line contingent therapy or ~~step therapy~~Step Therapy restrictions, as described on the ~~formulary~~Formulary; and/or

4. Are prescribed for clinical indications outside specified utilization management restrictions, as described on the ~~formulary~~Formulary.

B. CalOptima and its ~~Pharmacy Benefit Manager (PBM)~~Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA categorization, turn-around time, and notification standards as specified in ~~Attachment B –~~the Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified as routine requests as outlined in the ~~the Attachment B –~~Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

D. CalOptima and its ~~PBM~~PBM shall maintain appropriate communication with the ~~prescribing practitioner~~Prescribing Practitioner and/or ~~member~~Member or the ~~member's~~Member's ~~authorized representative~~Authorized Representative throughout the PA process to facilitate delivery of appropriate services.

E. The ~~PBM~~PBM or CalOptima shall provide a written response of approve, modify, ~~delay~~ defer for ~~medical necessity~~Medical Necessity information from the ~~prescribing practitioner~~Prescribing Practitioner, or deny to an authorization within twenty-four (24) hours after receipt of an expedited (preservice or concurrent) and standard request and thirty (30) calendar days for a retrospective request to the ~~prescribing practitioner~~Prescribing Practitioner and ~~member~~Member. A decision to modify or deny shall ~~be limited to a~~only be made by a CalOptima Pharmacist or Medical Director.

F. In the event that all information reasonably necessary to make a determination was not received, CalOptima may extend the timeframe of an authorization request if the following are met:

1. For an expedited preservice request once, for forty-eight (48) hours, if CalOptima asks the ~~member~~Member, the ~~member's~~Member's Authorized R~~r~~epresentative, or the Prescribing Provider for the specific information necessary to make the decision within twenty-four (24) hours of the receipt of the request;

2. For a standard preservice request once, for an additional fourteen (14) calendar days, if the ~~member~~Member or the ~~prescribing practitioner~~Prescribing Practitioner requested for an extension, or CalOptima can provide justification upon request by the Department of Health Care Services (DHCS) the need for additional information and how it is in the ~~member's~~Member's interest. If the extension was not requested by the ~~member~~Member, CalOptima shall make reasonable efforts to give the ~~member~~Member and Prescribing Provider oral notice of the delay. The Prescribing Provider shall be provided with an electronic Notice of Action (NOA) within twenty-four (24) hours of the decision and the ~~member~~Member shall be given a written NOA within two (2) business days of the decision. The NOA shall include the reason for the extension, the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. CalOptima shall send the NOA pursuant to Section III.G. of this Policy.

3. Upon receipt of all of the information reasonably necessary and requested by CalOptima, CalOptima shall approve, modify, or deny the request for Authorization within twenty-four (24) hours. ~~five (5) business days or seventy-two (72) hours for standard and expedited requests, respectively of the decision.~~

G. Participating pharmacies may dispense up to a ten (10) calendar day supply of the requested medication pending final decision of the PA, in accordance with CalOptima Policy GG.1403: ~~Member~~Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies and CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

H. For appropriately prescribed pain management medications for terminally ill patients when ~~medically necessary~~Medically Necessary CalOptima shall approve, modify, ~~delay~~ defer for information reasonably necessary to make a determination, or deny a PA in a timely fashion, appropriate for the nature of the ~~member's~~Member's condition, and not to exceed twenty-four (24) hours of the CalOptima's receipt of the information requested by the plan to make the decision.~~Authorized Rand not to exceed seventy-two (72) hours of the CalOptima's receipt of the information requested by the plan to make the decision.~~

1. If the request is modified, denied, or delay due to lack of information reasonably necessary to make a determination is required, CalOptima shall contact the provider within twenty-four (24) hours of the determination, with an explanation of the reason for the modification, denial or the need for additional information.

2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to modify, deny, or delay (due to lack of information reasonably necessary to make a determination) a PA for pain management for terminally ill patients.

3. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.

I. Newly enrolled ~~members~~Members may continue use of a covered benefit single-source drug which is part of a prescribed therapy in effect for the ~~member~~Member immediately prior to the date of enrollment, whether or not the drug is included on the ~~formulary~~Formulary, until the prescribed therapy is no longer prescribed by the Practitioner. PA may be required if the single-source drug is not on the ~~formulary~~Formulary.

J. ~~Members~~Members ~~determined eligible with the California Children's Services (CCSCCS) program prior to the implementation of the Whole Child Model program, scheduled no sooner than July 1, 2019, and transitioned into~~newly enrolled in the Whole-Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the ~~member's~~Member's ~~CCS~~CCS-eligible condition or conditions immediately prior to the date of transition of responsibility for the ~~member's~~Member's ~~CCS~~CCS services to CalOptima, whether or not the drug is included on the ~~formulary~~Formulary, without PA until the ~~member's~~Member's prescribing ~~CCS~~CCS provider has completed an assessment of the child or youth, created a treatment plan, and decides that the particular medication is no longer ~~medically necessary~~Medically Necessary, or the medication is no longer prescribed by the ~~member's~~Member's ~~CCS~~CCS provider.

K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and nationally-marketed drugs, unless ~~medical necessity~~Medical Necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the ~~member~~Member and a compound alternative is ~~medically necessary~~Medically Necessary.

L. CalOptima Pharmacy Management shall require generic substitution when an equivalent generic product is available for ~~members~~Members not meeting the following criteria:

1. CalOptima Pharmacy Management adheres to Title 22, Section 51003 of the California Code of Regulations: Authorization may be granted only for the lowest cost item or service covered by the program that meets the ~~member's~~Member's medical needs.

2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring generic substitution. The FDA has rated all generic drugs "A" or "B." Only "A" rated products are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.

   a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the same amount of time as the brand-name counterpart. For reformulations of a brand-name drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing. It requires generics to have the same quality, strength, purity, and stability as the brand name drugs. For these reasons, requests for brand versions should not be approved based on assumptions that there will be better efficacy or safety.

3. ~~Prior authorization~~Prior Authorization requests for use of a brand name product when a generic equivalent is available shall be considered for review when the following information is provided:

   a. Documentation from the ~~member's~~Member's prescription profile or from the ~~prescribing practitioner~~Prescribing Practitioner's progress notes that the ~~member~~Member has had a previous adequate trial of available generic equivalents within one hundred eighty (180) calendar days of the request.

   b. Documentation from the ~~member's~~Member's prescription profile or from the ~~prescribing practitioner~~Prescribing Practitioner's progress notes that the ~~member~~Member has had a previous adequate trial of therapeutic alternatives within one hundred eighty (180) calendar days of the request.

   c. Medical justification of why the ~~member~~Member is unable to use the generic equivalent and cannot use an alternative therapeutic equivalent.

   d. Documentation of a MedWatch form (Attachment C) by the ~~Prescribing Practitioner~~Prescribing Practitioner documenting the adverse event within the generic equivalent drug may be required.

   e. In cases of severe shortages of generic versions due to manufacturer problems, the brand version may be approved on a temporary basis until the situation is resolved.

   f. Certain drugs with a narrow therapeutic index do not require generic substitution for claims system adjudication. These drugs are listed in the CalOptima Approved Drug List.

M. ~~Prior authorization~~Prior Authorization decisions shall be classified as ~~medical necessity~~Medical Necessity and benefit (or administrative) requests. ~~Post-service request~~Post-service Requests are allowed for benefit requests only (~~excluded from the classification for medical necessity~~Medical Necessity requests are excluded).

N. If CalOptima fails to issue a NOA for ~~prior authorization~~Prior Authorization requests within the required time frame, it shall be considered a denial and shall constitute an Adverse Benefit Determination. The ~~member~~Member shall have the right to request an ~~appeal~~Appeal in accordance with CalOptima Policy GG.1410: ~~Appeal~~Appeals Process for Pharmacy Authorizations.

O. CalOptima Pharmacy Management shall review and update the CalOptima ~~Prior Authorization~~Prior Authorization guidelines when appropriate and, at a minimum, on an annual basis.

III. PROCEDURE

A. A ~~prescribing practitioner~~Prescribing Practitioner or a ~~participating pharmacy~~Participating Pharmacy representative shall submit a completed PA Form (Attachment A) to the ~~PBM~~PBM, in accordance with the instructions on the form, or shall contact the ~~PBM~~PBM PA center by telephone. A ~~member~~Member or the ~~member's~~Member's ~~authorized representative~~Authorized Representative may submit a PA by contacting CalOptima's Customer Service Department or via the CalOptima website.

B. The ~~PBM~~PBM, on behalf of CalOptima, shall review and classify all pharmaceutical PA requests using the timelines specified in ~~the Attachment B~~ the Pharmacy ~~Prior Authorization~~Prior

Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy ~~benefit~~Benefit (Attachment B), and based on the following:

1. Urgent ~~pre-service request~~Pre-service Request;

2. Urgent ~~concurrent request~~Concurrent Request;

3. Standard Request (non-urgent ~~pre-service request~~Pre-service Request); and

4. ~~Post-service request~~Post-service Request.

C. The ~~PBM~~PBM, on behalf of CalOptima, shall review all PA requests based on the ~~member's~~Member's individual needs, in accordance with criteria established by the CalOptima PA guidelines for drug utilization review that are consistent with current medical practice and the Title 22, California Code of Regulations definition of ~~Medical Necessity~~Medical Necessity, and that have been approved by CalOptima's Pharmacy and Therapeutics (P&T) Committee. Requests shall also be evaluated by the ~~PBM~~PBM and CalOptima to consider the ~~member's~~Member's condition, age, gender, ~~health network~~Health Network (to ensure appropriate responsibility for coverage), place of residence, and for other payers or other insurance coverage. The ~~PBM~~PBM and CalOptima shall obtain all clinical information, relevant to a ~~member's~~Member's care, to render a decision. The ~~PBM~~PBM's Pharmacy Technician and Clinical Pharmacist, and CalOptima's Pharmacy Technician, may only approve or defer a PA request. Requests that do not meet the CalOptima PA Guidelines shall be reviewed by a CalOptima Clinical Pharmacist and/or Medical Director.

1. The ~~PBM~~PBM Pharmacy Technician, ~~PBM~~PBM Pharmacist, a CalOptima Pharmacy Technician, or a CalOptima Clinical Pharmacist shall review all PA requests, except ~~post-service request~~Post-service Requests, and render a response within twenty-four (24) hours after receipt of the PA. Concurrent urgent and ~~post-service request~~Post-service Requests shall be reviewed by the ~~PBM~~PBM and CalOptima based on the timelines specified in the Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

2. If the PA request has sufficient clinical information to meet the CalOptima PA guidelines, the ~~PBM~~PBM shall approve the PA and notify the ~~prescribing practitioner~~Prescribing Practitioner and ~~participating pharmacy~~Participating Pharmacy representative by facsimile.

3. If the PA request has insufficient information to meet the CalOptima PA guidelines, the ~~PBM~~PBM shall defer the PA for additional ~~medical necessity~~Medical Necessity information and notify the ~~prescribing practitioner~~Prescribing Practitioner and/or the ~~member's~~Member's ~~participating pharmacy~~Participating Pharmacy by facsimile.

   a. The ~~prescribing practitioner~~Prescribing Practitioner and/or the ~~member's~~Member's ~~participating pharmacy~~Participating Pharmacy shall be notified of the deferral for requests with insufficient information. The notice shall include a reason for the deferral and date of when a response is needed to render a decision.

   b. If additional information is not received in the timeframe requested, the request shall be forwarded to CalOptima to modify the PA request to a ~~formulary~~Formulary alternative, delay due to missing information necessary to make a determination, or deny based on the timelines specified in the Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

4. If all information reasonably necessary is received and the information provided by the ~~prescribing practitioner~~Prescribing Practitioner or ~~participating pharmacy~~Participating Pharmacy is insufficient for approval, the ~~PBM~~PBM's Pharmacist shall make recommendation to deny or modify to a ~~formulary~~Formulary alternative the PA request and shall forward the PA request to a CalOptima Pharmacist for review. CalOptima shall render a decision pursuant to timelines specified in the Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

D. CalOptima shall notify the ~~member~~Member, the ~~member's~~Member's ~~authorized representative~~Authorized Representative, if applicable, and ~~prescribing practitioner~~Prescribing Practitioner, of any denial, delay, modification, termination, suspension, or reduction of the level of treatment or services currently underway, or medication carve out, in a written NOA, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring ~~Prior Authorization~~Prior Authorization. The NOA shall be provided within the PA time frame as specified in the Pharmacy ~~Prior Authorization~~Prior Authorization and ~~Appeal~~Appeals: Time frames for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

E. The written NOA shall contain information as required by applicable state and federal regulations and outlined in the CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring ~~Prior Authorization~~Prior Authorization. It shall also:

1. ~~Describe the~~Provide a statement of action CalOptima is taking on the request;

2. Clearly and concisely describe the specific reason(s) for the deny, modify, delay, termination, suspension, reduction of the level of treatment or services currently underway, or medication carve out decision in easy to understand language and provide a reference to the CalOptima Pharmacy ~~Prior Authorization~~Prior Authorization Guidelines on which the decision was based;

3. Contain all of the following for decisions based in whole or in part on ~~medical necessity~~Medical Necessity:

   a. Provide a description of the criteria or guidelines used to include a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines;

   b. Describe the clinical reasons for the decision and explicitly state how the ~~member's~~Member's condition does not meet the criteria or guidelines;

4. Describe how the ~~member~~Member or ~~prescribing practitioner~~Prescribing Practitioner can obtain the medication for PA requests that exceed the ~~formulary~~Formulary quantity limit. CalOptima shall advise the ~~member~~Member or ~~prescribing practitioner~~Prescribing Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of quantity limit;

5. Describe how the ~~member~~Member or ~~prescribing practitioner~~Prescribing Practitioner can obtain a ~~formulary~~Formulary alternative on the CalOptima Approved Drug List without a PA;

6. Define how the ~~member~~Member and ~~prescribing practitioner~~Prescribing Practitioner may request, free of charge, copies of all documents and records relevant to the NOA, including the actual benefit provision, guideline, protocol, or other criteria on which the decision was based;

7. Inform the ~~prescribing practitioner~~Prescribing Practitioner of the availability of an appropriate practitioner to discuss the denial and provide contact instructions;

8. Include the ~~member~~Member and prescriber's ~~appeal~~Appeal rights, an explanation of the ~~appeal~~Appeal process, and instructions on how to submit an ~~appeal~~Appeal;

9. Explain that the ~~member~~Member or ~~prescribing practitioner~~Prescribing Practitioner can provide written comments, documents, or other information to ~~appeal~~Appeal the denial;

10. Include the name and direct telephone number of the decision maker on the ~~prescribing practitioner~~Prescribing Practitioner notification; and

11. Include a "Your Rights" attachment, along with the nondiscrimination notice and language assistance taglines, as set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring ~~Prior Authorization~~Prior Authorization.

F. CalOptima shall communicate ~~the decision~~ the decision to deny, delay, modify, ~~,~~ terminate~~,~~, suspend, ~~or~~ reduce the level of ~~suspend, or reduce of the level of~~ treatment or services currently underway, or of a medication carve out ~~or services currently underway, or of a mediation carve out~~ to the ~~member~~Member, in writing, which shall be dated and postmarked within two (2) business days of the decision.

G. CalOptima shall notify the ~~prescribing practitioner~~Prescribing Practitioner of the decision to approve, deny, delay, modify, terminate~~,~~ suspend, or reduce the level of treatment or services currently underway, or of a medication carve out ~~suspend, or reduce of the level of treatment or services currently underway, or of a mediation carve out~~ initially by facsimile, then in writing~~,~~ ~~except for decisions rendered retrospectively.~~ The written notification of the decision shall be dated within twenty-four (24) hours of the decision. For decisions made retroactively, only ~~the written~~facsimile notice shall be required.

H. In accordance with CalOptima Policy GG.1410: ~~Appeal~~Appeals Process for Pharmacy Authorizations, a ~~prescribing practitioner~~Prescribing Practitioner, ~~member~~Member, or ~~member's~~Member's ~~authorized representative~~Authorized Representative may ~~appeal~~Appeal any decision that involves the delay, modification, or denial of services based on ~~medical necessity~~Medical Necessity, termination, suspension, or reduction of the level of treatment or services currently under way, or a determination that the requested service was not a covered benefit within sixty (60) calendar days from the date on the NOA.

I. For terminations, suspensions, or reductions of previously authorized services, CalOptima shall notify ~~members~~Members at least ten (10) calendar days before the date of the action, with the exception of circumstances permitted under Title 42 of the Code of Federal Regulations (CFR), sections 431.213 and 431.214.

IV. ATTACHMENT(S)

A. Prior Authorization (PA) Form
B. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit
C. MedWatch Form

V. REFERENCE(S)

A. 2017~~9~~ NCQA Health Plan Accreditation-UM Standards
B. California Business and Professions Code, Section 4039
C. California Health and Safety Code section 1367.215(a)
D. California Welfare and Institutions Code, Sections 14185 and 14094.13(d).
E. CalOptima Approved Drug List
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
H. CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations
I. CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization
J. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
L. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
M. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
N. Title 22, California Code of Regulations, §§ 51003 and 51303
O. Title 42, California Code of Regulations, §§ 431.213-214 and 438.910(b).

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/23/2014	Department of Health Care Services (DHCS)
11/10/2015	Department of Health Care Services (DHCS)
04/19/2016	Department of Health Care Services (DHCS)
08/09/2016	Department of Health Care Services (DHCS)
10/18/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	05/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	01/01/2001	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2002	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	08/01/2003	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	04/01/2007	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2011	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2013	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	05/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	03/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	10/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	02/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	06/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	12/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2017	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	09/06/2018	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2019	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	TBD	GG.1401	Pharmacy Authorization Process	Medi-Cal

1

IX. GLOSSARY

Term	Definition
~~Authorized Representative~~	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009A: Access by Member's Personal Representative.~~
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).~~A request by the member, Member's authorized representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.~~
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Concurrent Request	A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to members without the need for Prior Authorization.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also, a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1. In the case of a Grievance that constitutes an "appeal" under 42 CFR Section 438.400(b), the provider must have the Member's written consent before filing the Grievance on behalf of the Member.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), ~~P~~physician ~~Medical G~~group ~~(PMG)~~ under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that Health Network.
Health Risk Assessment	A health questionnaire, used to provide members with an evaluation of their health risks and quality of life.
Individual Care Plan	A plan of care developed after an assessment of the member's social and health care needs that reflects the member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).~~.~~
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Post-service Request	A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a member.
Pre-service Request	A request for coverage of pharmaceutical services that CalOptima must approve in advance, in whole or in part.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.~~A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.~~
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

Term	Definition
~~Urgent Request (Pharmacy)~~	~~A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations:~~ ~~Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or~~ ~~In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.~~
Whole Child Model	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions~~An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers~~.

1

Policy:	GG.1401
Title:	**Pharmacy Authorization Process**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Pharmacy Prior Authorization (PA) process.

II. POLICY

A. CalOptima shall require a Prior Authorization for medications and supplies that:

1. Are not listed on the closed Formulary, also known as the Approved Drug List;
2. Are on the Formulary but exceed Formulary limitations for quantity, refill frequency, or duration of therapy;
3. Do not meet on-line contingent therapy or Step Therapy restrictions, as described on the Formulary; and/or
4. Are prescribed for clinical indications outside specified utilization management restrictions, as described on the Formulary.

B. CalOptima and its Pharmacy Benefit Manager (PBM) shall process requests for PA using the PA categorization, turn-around time, and notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

C. Requests marked as urgent that do not meet the definition for expedited review shall be reclassified as routine requests as outlined in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

D. CalOptima and its PBM shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the PA process to facilitate delivery of appropriate services.

E. The PBM or CalOptima shall provide a written response of approve, modify, defer for Medical Necessity information from the Prescribing Practitioner, or deny to an authorization within twenty-four (24) hours after receipt of an expedited (preservice or concurrent) and standard request and thirty (30) calendar days for a retrospective request to the Prescribing Practitioner and Member. A decision to modify or deny shall only be made by a CalOptima Pharmacist or Medical Director.

F. In the event that all information reasonably necessary to make a determination was not received, CalOptima may extend the timeframe of an authorization request if the following are met:

1. For an expedited preservice request once, for forty-eight (48) hours, if CalOptima asks the Member, the Member's Authorized Representative, or the Prescribing Provider for the specific information necessary to make the decision within twenty-four (24) hours of the receipt of the request;

2. For a standard preservice request once, for an additional fourteen (14) calendar days, if the Member or the Prescribing Practitioner requested for an extension, or CalOptima can provide justification upon request by the Department of Health Care Services (DHCS) the need for additional information and how it is in the Member's interest. If the extension was not requested by the Member, CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay. The Prescribing Provider shall be provided with an electronic Notice of Action (NOA) within twenty-four (24) hours of the decision and the Member shall be given a written NOA within two (2) business days of the decision. The NOA shall include the reason for the extension, the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. CalOptima shall send the NOA pursuant to Section III.G. of this Policy.

3. Upon receipt of all of the information reasonably necessary and requested by CalOptima, CalOptima shall approve, modify, or deny the request for Authorization within twenty-four (24) hours.

G. Participating pharmacies may dispense up to a ten (10) calendar day supply of the requested medication pending final decision of the PA, in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies and CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

H. For appropriately prescribed pain management medications for terminally ill patients when Medically Necessary CalOptima shall approve, modify, defer for information reasonably necessary to make a determination, or deny a PA in a timely fashion, appropriate for the nature of the Member's condition, and not to exceed twenty-four (24) hours of the CalOptima's receipt of the information requested by the plan to make the decision.

1. If the request is modified, denied, or delay due to lack of information reasonably necessary to make a determination is required, CalOptima shall contact the provider within twenty-four (24) hours of the determination, with an explanation of the reason for the modification, denial or the need for additional information.

2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to modify, deny, or delay (due to lack of information reasonably necessary to make a determination) a PA for pain management for terminally ill patients.

3. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.

I. Newly enrolled Members may continue use of a covered benefit single-source drug which is part of a prescribed therapy in effect for the Member immediately prior to the date of enrollment, whether

or not the drug is included on the Formulary, until the prescribed therapy is no longer prescribed by the Practitioner. PA may be required if the single-source drug is not on the Formulary.

J. Members newly enrolled in the Whole-Child Model program shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-eligible condition or conditions immediately prior to the date of transition of responsibility for the Member's CCS services to CalOptima, whether or not the drug is included on the Formulary, without PA until the Member's prescribing CCS provider has completed an assessment of the child or youth, created a treatment plan, and decides that the particular medication is no longer Medically Necessary, or the medication is no longer prescribed by the Member's CCS provider.

K. CalOptima shall require the use of a U.S. Food and Drug Administration (FDA)-approved and nationally-marketed drugs, unless Medical Necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the Member and a compound alternative is Medically Necessary.

L. CalOptima Pharmacy Management shall require generic substitution when an equivalent generic product is available for Members not meeting the following criteria:

1. CalOptima Pharmacy Management adheres to Title 22, Section 51003 of the California Code of Regulations: Authorization may be granted only for the lowest cost item or service covered by the program that meets the Member's medical needs.

2. CalOptima Pharmacy Management shall utilize the FDA bioequivalent ratings when requiring generic substitution. The FDA has rated all generic drugs "A" or "B." Only "A" rated products are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.

    a. The FDA ensures that generic drugs deliver the same amount of active ingredients in the same amount of time as the brand-name counterpart. For reformulations of a brand-name drug or generic versions of a drug, it reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing. It requires generics to have the same quality, strength, purity, and stability as the brand name drugs. For these reasons, requests for brand versions should not be approved based on assumptions that there will be better efficacy or safety.

3. Prior Authorization requests for use of a brand name product when a generic equivalent is available shall be considered for review when the following information is provided:

    a. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of available generic equivalents within one hundred eighty (180) calendar days of the request.

    b. Documentation from the Member's prescription profile or from the Prescribing Practitioner's progress notes that the Member has had a previous adequate trial of therapeutic alternatives within one hundred eighty (180) calendar days of the request.

    c. Medical justification of why the Member is unable to use the generic equivalent and cannot use an alternative therapeutic equivalent.

    d. Documentation of a MedWatch form (Attachment C) by the Prescribing Practitioner documenting the adverse event within the generic equivalent drug may be required.

e. In cases of severe shortages of generic versions due to manufacturer problems, the brand version may be approved on a temporary basis until the situation is resolved.

f. Certain drugs with a narrow therapeutic index do not require generic substitution for claims system adjudication. These drugs are listed in the CalOptima Approved Drug List.

M. Prior Authorization decisions shall be classified as Medical Necessity and benefit (or administrative) requests. Post-service Requests are allowed for benefit requests only (Medical Necessity requests are excluded).

N. If CalOptima fails to issue a NOA for Prior Authorization requests within the required time frame, it shall be considered a denial and shall constitute an Adverse Benefit Determination. The Member shall have the right to request an Appeal in accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations.

O. CalOptima Pharmacy Management shall review and update the CalOptima Prior Authorization guidelines when appropriate and, at a minimum, on an annual basis.

III. PROCEDURE

A. A Prescribing Practitioner or a Participating Pharmacy representative shall submit a completed PA Form (Attachment A) to the PBM, in accordance with the instructions on the form, or shall contact the PBM PA center by telephone. A Member or the Member's Authorized Representative may submit a PA by contacting CalOptima's Customer Service Department or via the CalOptima website.

B. The PBM, on behalf of CalOptima, shall review and classify all pharmaceutical PA requests using the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B), and based on the following:

1. Urgent Pre-service Request;

2. Urgent Concurrent Request;

3. Standard Request (non-urgent Pre-service Request); and

4. Post-service Request.

C. The PBM, on behalf of CalOptima, shall review all PA requests based on the Member's individual needs, in accordance with criteria established by the CalOptima PA guidelines for drug utilization review that are consistent with current medical practice and the Title 22, California Code of Regulations definition of Medical Necessity, and that have been approved by CalOptima's Pharmacy and Therapeutics (P&T) Committee. Requests shall also be evaluated by the PBM and CalOptima to consider the Member's condition, age, gender, Health Network (to ensure appropriate responsibility for coverage), place of residence, and for other payers or other insurance coverage. The PBM and CalOptima shall obtain all clinical information, relevant to a Member's care, to render a decision. The PBM's Pharmacy Technician and Clinical Pharmacist, and CalOptima's Pharmacy Technician, may only approve or defer a PA request. Requests that do not meet the CalOptima PA Guidelines shall be reviewed by a CalOptima Clinical Pharmacist and/or Medical Director.

1. The PBM Pharmacy Technician, PBM Pharmacist, a CalOptima Pharmacy Technician, or a CalOptima Clinical Pharmacist shall review all PA requests, except Post-service Requests, and render a response within twenty-four (24) hours after receipt of the PA. Concurrent urgent and Post-service Requests shall be reviewed by the PBM and CalOptima based on the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

2. If the PA request has sufficient clinical information to meet the CalOptima PA guidelines, the PBM shall approve the PA and notify the Prescribing Practitioner and Participating Pharmacy representative by facsimile.

3. If the PA request has insufficient information to meet the CalOptima PA guidelines, the PBM shall defer the PA for additional Medical Necessity information and notify the Prescribing Practitioner and/or the Member's Participating Pharmacy by facsimile.

    a. The Prescribing Practitioner and/or the Member's Participating Pharmacy shall be notified of the deferral for requests with insufficient information. The notice shall include a reason for the deferral and date of when a response is needed to render a decision.

    b. If additional information is not received in the timeframe requested, the request shall be forwarded to CalOptima to modify the PA request to a Formulary alternative, delay due to missing information necessary to make a determination, or deny based on the timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

4. If all information reasonably necessary is received and the information provided by the Prescribing Practitioner or Participating Pharmacy is insufficient for approval, the PBM's Pharmacist shall make recommendation to deny or modify to a Formulary alternative the PA request and shall forward the PA request to a CalOptima Pharmacist for review. CalOptima shall render a decision pursuant to timelines specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit.

D. CalOptima shall notify the Member, the Member's Authorized Representative, if applicable, and Prescribing Practitioner, of any denial, delay, modification, termination, suspension, or reduction of the level of treatment or services currently underway, or medication carve out, in a written NOA, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The NOA shall be provided within the PA time frame as specified in the Pharmacy Prior Authorization and Appeals: Time frames for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment B).

E. The written NOA shall contain information as required by applicable state and federal regulations and outlined in the CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization. It shall also:

1. Provide a statement of action CalOptima is taking on the request;

2. Clearly and concisely describe the specific reason(s) for the deny, modify, delay, termination, suspension, reduction of the level of treatment or services currently underway, or medication carve out decision in easy to understand language and provide a reference to the CalOptima Pharmacy Prior Authorization Guidelines on which the decision was based;

3. Contain all of the following for decisions based in whole or in part on Medical Necessity:

   a. Provide a description of the criteria or guidelines used to include a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines;

   b. Describe the clinical reasons for the decision and explicitly state how the Member's condition does not meet the criteria or guidelines;

4. Describe how the Member or Prescribing Practitioner can obtain the medication for PA requests that exceed the Formulary quantity limit. CalOptima shall advise the Member or Prescribing Practitioner how to fill a prescription for a lesser quantity when a denial is made on the basis of quantity limit;

5. Describe how the Member or Prescribing Practitioner can obtain a Formulary alternative on the CalOptima Approved Drug List without a PA;

6. Define how the Member and Prescribing Practitioner may request, free of charge, copies of all documents and records relevant to the NOA, including the actual benefit provision, guideline, protocol, or other criteria on which the decision was based;

7. Inform the Prescribing Practitioner of the availability of an appropriate practitioner to discuss the denial and provide contact instructions;

8. Include the Member and prescriber's Appeal rights, an explanation of the Appeal process, and instructions on how to submit an Appeal;

9. Explain that the Member or Prescribing Practitioner can provide written comments, documents, or other information to Appeal the denial;

10. Include the name and direct telephone number of the decision maker on the Prescribing Practitioner notification; and

11. Include a "Your Rights" attachment, along with the nondiscrimination notice and language assistance taglines, as set forth in CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization.

F. CalOptima shall communicate the decision to deny, delay, modify, terminate, suspend, or reduce the level of treatment or services currently underway, or of a medication carve out to the Member, in writing, which shall be dated and postmarked within two (2) business days of the decision.

G. CalOptima shall notify the Prescribing Practitioner of the decision to approve, deny, delay, modify, terminate, suspend, or reduce the level of treatment or services currently underway, or of a medication carve out initially by facsimile, then in writing. The written notification of the decision shall be dated within twenty-four (24) hours of the decision. For decisions made retroactively, only facsimile notice shall be required.

H. In accordance with CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations, a Prescribing Practitioner, Member, or Member's Authorized Representative may Appeal any decision that involves the delay, modification, or denial of services based on Medical Necessity, termination, suspension, or reduction of the level of treatment or services currently under way, or a

determination that the requested service was not a covered benefit within sixty (60) calendar days from the date on the NOA.

I. For terminations, suspensions, or reductions of previously authorized services, CalOptima shall notify Members at least ten (10) calendar days before the date of the action, with the exception of circumstances permitted under Title 42 of the Code of Federal Regulations (CFR), sections 431.213 and 431.214.

IV. ATTACHMENT(S)

A. Prior Authorization (PA) Form
B. Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit
C. MedWatch Form

V. REFERENCE(S)

A. 2019 NCQA Health Plan Accreditation-UM Standards
B. California Business and Professions Code, Section 4039
C. California Health and Safety Code section 1367.215(a)
D. California Welfare and Institutions Code, Sections 14185 and 14094.13(d).
E. CalOptima Approved Drug List
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
H. CalOptima Policy GG.1410: Appeals Process for Pharmacy Authorizations
I. CalOptima Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization
J. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
L. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
M. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives.
N. Title 22, California Code of Regulations, §§ 51003 and 51303
O. Title 42, California Code of Regulations, §§ 431.213-214 and 438.910(b).

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/23/2014	Department of Health Care Services (DHCS)
11/10/2015	Department of Health Care Services (DHCS)
04/19/2016	Department of Health Care Services (DHCS)
08/09/2016	Department of Health Care Services (DHCS)
10/18/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	05/01/1999	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	01/01/2001	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	03/01/2002	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	08/01/2003	GG.1401	Prior Authorization Process of Medication: The CalOptima Pharmacy Authorization System (CPAS) Process	Medi-Cal
Revised	04/01/2007	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2011	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2013	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	05/01/2014	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	03/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	10/01/2015	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	02/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	06/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	12/01/2016	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	07/01/2017	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	09/06/2018	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	01/01/2019	GG.1401	Pharmacy Authorization Process	Medi-Cal
Revised	TBD	GG.1401	Pharmacy Authorization Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Concurrent Request	A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to members without the need for Prior Authorization.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision. Also, a Complaint from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Section 1368 and 1368.1. In the case of a Grievance that constitutes an "appeal" under 42 CFR Section 438.400(b), the provider must have the Member's written consent before filing the Grievance on behalf of the Member.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that Health Network.
Health Risk Assessment	A health questionnaire, used to provide members with an evaluation of their health risks and quality of life.
Individual Care Plan	A plan of care developed after an assessment of the member's social and health care needs that reflects the member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or

Term	Definition
	treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Participating Pharmacy	Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to members.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Post-service Request	A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a member.
Pre-service Request	A request for coverage of pharmaceutical services that CalOptima must approve in advance, in whole or in part.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.
Whole Child Model	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1

CalOptima
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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Submit requests to the Prior Authorization Center at:

	Fax	Appeal Fax	Call
Medi-Cal/ CalWrap	858-357-2557	714-954-2280	888-807-5705
OneCare HMO SNP (Medicare Part D)	858-357-2556	858-357-2556	800-819-5532
OneCare Connect (Medicare-Medicaid)	858-357-2556	858-357-2556	800-819-5480

What is the urgency?	Request is for a hospital discharge medication?
☐ Standard ☐ Urgent* ☐ Retroactive	☐ Yes ☐ No

* The prescriber attests that applying the standard turn-around time could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PATIENT INFORMATION

Patient Name: _____

Patient CalOptima ID #: _____

Gender: ☐ Male ☐ Female DOB: _____

Other Primary Insurance? ☐ Yes ☐ No ☐ Unknown

Name of Primary Insurance: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Specialty: _____

Prescriber NPI #: _____

Prescriber Signature: _____

For Medicare Part D, an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber may request a coverage determination

PATIENT LOCATION INFORMATION

Patient Location:
☐ Home ☐ B&C ☐ Sub-Acute ☐ SNF ☐ ICF

Name of Facility: _____

Facility Phone #: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy NPI #: _____

Pharmacy Phone #: _____

Pharmacy Fax #: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY
Drug Name: _____ NDC#: _____			

REVIEW CRITERIA:

What is the diagnosis? _____ **OR** ICD-10 code: _____

New Therapy? ☐ Yes ☐ No # Refills? _____ Date of Rx: _____

Medical Justification Supporting Statement *(include formulary drugs that have been tried, why the requested drug is medically required, why formulary drugs would not be appropriate, and applicable labs).*

If applicable, include dates and reason for retroactive authorization requests.

The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Back to Agenda Back to Item

~~**Attachment B (for GG.1401 and GG.1410):**~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours of receipt of the ~~decision[2]~~ request[2] (electronic~~/ and~~ written notification) **Member:** Within 2 business days of the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within ~~24~~ hours ~~5 working days~~ of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The Member or the Member's provider may request for an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[2,3~~3~~,~~6~~]. ▪ The Delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immedately processed as such[2].	- **Practitioner:** Within 24 hours of the decision[2], not to exceed 14 calendar days from the receipt of the request[3] (electronic~~/ and~~ written notification) - **Member:** Within 2 business days of making the decision[2~~2~~,~~,7~~] not to exceed 14 calendar days from the receipt of the request[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or ~~Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or~~ • • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within 24 hours of receipt of the ~~decision[2]~~ request[2] ~~,3~~ (electronic~~/ and~~ written notification) - **Member:** Within 2 business days of making the decision ~~Within 24 hours of the decision[2] ,4~~ (written notification)

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA) Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • ~~Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or~~ • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision ~~[2]~~ but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2 3~~3~~] (electronic~~/ and~~ written notification) **Member:** Within 2 business days of the decision~~[2]~~ but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2 3~~3~~] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA Timeliness of UM decision~~,~~[3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of receipt of the request ~~[2]making the decision[2,3]~~ (electronic~~/ and~~ written notification) - **Member:** Within 24 hours of receipt of the request~~of making the decision~~[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 24 hours of making the decision~~.~~ ~~[2]~~ but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] (electronic/written notification) - **Member:** Within 2 business days of the decision~~[2]~~ but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] [3](written notification)

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5,6]		**Notice of Appeal Resolution (NAR) Notification Timeframe**
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5,6].	- **Practitioner:** Within 30 calendar days from the receipt of the request [5] (electronic & written notification) - **Member:** Within 30 of receipt of the request[5] -(written notification)

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	~~—~~A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5,6]. ~~— The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:~~ ~~Within 24 hours of receipt of the urgent preservice request, the Plan asks the member or the member's representative for the specific information necessary to make the decision.~~ ~~The Plan gives the member or member's authorized representative at least 48 hours to provide the information.~~ ~~The extension period, within which a decision must be made by the Plan, begins:~~ ~~On the date when the Plan receives the member's response (even if not all of the information is provided), or~~ ~~At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative[5].~~ - - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or~~,~~ health ~~or safety~~ of the member or ~~others~~the member's ability to regain maximum function, based on a prudent layperson's judgment, ~~due to the member's psychological state,~~ or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of the decision (electronic & written notification)[5,6] - **Member:** Within 72 hours of the decision (oral and written notification)[5]

~~**Attachment B (for GG.1401 and GG.1410):**~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Postservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request [5,6~~5~~].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,~~5~~] (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,~~5~~] (written notification).

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1)
~~1.~~2. County Organized Health Systems Coordinated Care Initiative Boilerplate Contract
~~2.~~
~~3. California Health and Safety Code Sections (HSC) 1367.01(h)~~
~~4.~~3. UM 5: Timeliness of UM decisions, Element C~~E~~: Notification of Pharmacy Decisions, 202018~~8~~ HP Accreditation UM Standards.
~~5.~~4. UM 5: Timeliness of UM decisions, Element D~~E~~: UM Timeliness ~~Report of Pharmacy UM Decisions~~, 202018~~8~~ HP Accreditation UM Standards.
~~6.~~5. UM 9: Timeliness of the Appeal Process, Element B~~E~~: Factor 1 to 3, 2020 HP Accreditation UM Standards. ~~-~~
~~7.~~ All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
~~8.~~6.

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours of receipt of the request[2] (electronic/written notification) - **Member:** Within 2 business days of the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The Member or the Member's provider may request for an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[2,3,]. ▪ The Delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** Within 24 hours of the decision[2], not to exceed 14 calendar days from the receipt of the request[3] (electronic/written notification) - **Member:** Within 2 business days of making the decision[2]. not to exceed 14 calendar days from the receipt of the request[3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within 24 hours of receipt of the request[2] (electronic/written notification) - **Member:** Within 2 business days of making the decision [2] (written notification)

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA) Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3] (electronic/written notification) - **Member:** Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA Timeliness of UM decision[3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of receipt of the request [2,3] (electronic/written notification) - **Member:** Within 24 hours of receipt of the request[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] (electronic/written notification) - **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] [3](written notification)

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5,6]		Notice of Appeal Resolution (NAR) Notification Timeframe
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5,6].	- **Practitioner:** Within 30 calendar days from the receipt of the request [5] (electronic & written notification) - **Member:** Within 30 of receipt of the request[5] (written notification)
Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	- A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5,6]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of the decision (electronic & written notification)[5,6] - **Member:** Within 72 hours of the decision (oral and written notification)[5]
Post-Service Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request [5,6].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,5] (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,5] (written notification).

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1)
2. County Organized Health Systems Coordinated Care Initiative Boilerplate Contract
3. UM 5: Timeliness of UM decisions, Element C: Notification of Pharmacy Decisions, 2020 HP Accreditation UM Standards.
4. UM 5: Timeliness of UM decisions, Element D: UM Timeliness Report, 2020 HP Accreditation UM Standards.
5. UM 9: Timeliness of the Appeal Process, Element B: Factor 1 to 3, 2020 HP Accreditation UM Standards.
6. All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

Reset Form

U.S. Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use errors

Form Approved: OMB No. 0910-0291, Expires: 9/30/2018
See PRA statement on reverse.

FDA USE ONLY

Triage unit sequence #

FDA Rec. Date

Note: For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-Jul-2015.

A. PATIENT INFORMATION

1. Patient Identifier — In Confidence

2. Age ☐ Year(s) ☐ Month(s) ☐ Week(s) ☐ Days(s)
or Date of Birth *(e.g., 05 Feb 1926)* ___ – ___ – ___

3. Sex ☐ Female ☐ Male

4. Weight ☐ lb ☐ kg

5.a. Ethnicity *(Check single best answer)* ☐ Hispanic/Latino ☐ Not Hispanic/Latino

5.b. Race *(Check all that apply)* ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

B. ADVERSE EVENT, PRODUCT PROBLEM

1. Check all that apply
☐ Adverse Event ☐ Product Problem *(e.g., defects/malfunctions)*
☐ Product Use Error ☐ Problem with Different Manufacturer of Same Medicine

2. Outcome Attributed to Adverse Event *(Check all that apply)*
☐ Death *Include date (dd-mmm-yyyy):* ___ – ___ – ___
☐ Life-threatening ☐ Disability or Permanent Damage
☐ Hospitalization – initial or prolonged ☐ Congenital Anomaly/Birth Defects
☐ Other Serious (Important Medical Events)
☐ Required Intervention to Prevent Permanent Impairment/Damage (Devices)

3. Date of Event *(dd-mmm-yyyy)* ___ – ___ – ___

4. Date of this Report *(dd-mmm-yyyy)* ___ – ___ – ___

5. Describe Event, Problem or Product Use Error

(Continue on page 3)

6. Relevant Tests/Laboratory Data, Including Dates

(Continue on page 3)

7. Other Relevant History, Including Preexisting Medical Conditions *(e.g., allergies, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)*

(Continue on page 3)

C. PRODUCT AVAILABILITY

2. Product Available for Evaluation? *(Do not send product to FDA)*
☐ Yes ☐ No ☐ Returned to Manufacturer on *(dd-mmm-yyyy)* ___ – ___ – ___

D. SUSPECT PRODUCTS

1. Name, Manufacturer/Compounder, Strength *(from product label)*

#1 – Name and Strength	#1 – NDC # or Unique ID
#1 – Manufacturer/Compounder	#1 – Lot #
#2 – Name and Strength	#2 – NDC # or Unique ID
#2 – Manufacturer/Compounder	#2 – Lot #

3.	Dose or Amount	Frequency	Route
#1			
#2			

4. Dates of Use *(From/To for each) (If unknown, give duration, or best estimate) (dd-mmm-yyyy)*
#1
#2

5. Diagnosis or Reason for Use *(Indication)*
#1
#2

6. Is the Product Compounded?
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

7. Is the Product Over-the-Counter?
#1 ☐ Yes ☐ No
#2 ☐ Yes ☐ No

8. Expiration Date *(dd-mmm-yyyy)*
#1 ___ – ___ – ___ #2 ___ – ___ – ___

9. Event Abated After Use Stopped or Dose Reduced?
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

10. Event Reappeared After Reintroduction?
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

E. SUSPECT MEDICAL DEVICE

1. Brand Name

2. Common Device Name — 2b. Procode

3. Manufacturer Name, City and State

4. Model # — Lot # — 5. Operator of Device ☐ Health Professional ☐ Lay User/Patient ☐ Other

Catalog # — Expiration Date *(dd-mmm-yyyy)* ___ – ___ – ___

Serial # — Unique Identifier (UDI) #

6. If Implanted, Give Date *(dd-mmm-yyyy)* ___ – ___ – ___

7. If Explanted, Give Date *(dd-mmm-yyyy)* ___ – ___ – ___

8. Is this a single-use device that was reprocessed and reused on a patient? ☐ Yes ☐ No

9. If Yes to Item 8, Enter Name and Address of Reprocessor

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product names and therapy dates *(Exclude treatment of event)*

(Continue on page 3)

G. REPORTER *(See confidentiality section on back)*

1. Name and Address

Last Name: — First Name:

Address:

City: — State/Province/Region:

Country: — ZIP/Postal Code:

Phone #: — Email:

2. Health Professional? ☐ Yes ☐ No

3. Occupation

4. Also Reported to: ☐ Manufacturer/ Compounder ☐ User Facility ☐ Distributor/Importer

5. If you do NOT want your identity disclosed to the manufacturer, please mark this box: ☐

PLEASE TYPE OR USE BLACK INK

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ADVICE ABOUT VOLUNTARY REPORTING

Detailed instructions available at: http://www.fda.gov/medwatch/report/consumer/instruct.htm

Report adverse events, product problems or product use errors with:

- Medications *(drugs or biologics)*
- Medical devices *(including in-vitro diagnostics)*
- Combination products *(medication & medical devices)*
- Human cells, tissues, and cellular and tissue-based products
- Special nutritional products *(dietary supplements, medical foods, infant formulas)*
- Cosmetics
- Food *(including beverages and ingredients added to foods)*

Report product problems - quality, performance or safety concerns such as:

- Suspected counterfeit product
- Suspected contamination
- Questionable stability
- Defective components
- Poor packaging or labeling
- Therapeutic failures (product didn't work)

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- Death
- Life-threatening
- Hospitalization - initial or prolonged
- Disability or permanent damage
- Congenital anomaly/birth defect
- Required intervention to prevent permanent impairment or damage (devices)
- Other serious (important medical events)

Report even if:

- You're not certain the product caused the event
- You don't have all the details

How to report:

- Just fill in the sections that apply to your report
- Use section D for all products except medical devices
- Attach additional pages if needed
- Use a separate form for each patient
- Report either to FDA or the manufacturer *(or both)*

Other methods of reporting:

- 1-800-FDA-0178 - To FAX report
- 1-800-FDA-1088 - To report by phone
- www.fda.gov/medwatch/report.htm - To report online

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

If your report involves a serious adverse event with a vaccine, call 1-800-822-7967 to report.

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

-Fold Here-

-Fold Here-

The information in this box applies only to requirements of the Paperwork Reduction Act of 1995

The burden time for this collection of information has been estimated to average 40 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Department of Health and Human Services
Food and Drug Administration
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

Please DO NOT RETURN this form to the PRA Staff e-mail to the left.

OMB statement:
"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

FORM FDA 3500 (10/15) (Back) **Please Use Address Provided Below -- Fold in Thirds, Tape and Mail**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Food and Drug Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES OR APO/FPO

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NO. 946 ROCKVILLE MD

POSTAGE WILL BE PAID BY FOOD AND DRUG ADMINISTRATION

MEDWATCH
The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787

Back to Agenda Back to Item

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U.S. Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

FORM FDA 3500 (10/15) *(continued)*

(CONTINUATION PAGE)

For VOLUNTARY reporting of adverse events and product problems

Back to Form

B.5. Describe Event or Problem *(continued)*

Back to Form

B.6. Relevant Tests/Laboratory Data, Including Dates *(continued)*

Back to Form

B.7. Other Relevant History, Including Preexisting Medical Conditions *(e.g., allergies, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)* *(continued)*

Back to Form

F. Concomitant Medical Products and Therapy Dates *(Exclude treatment of event)* *(continued)*

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Actions Related to COVID-19 Vaccines for CalOptima Direct and CalOptima Community Network Members with AltaMed Health Services Corporation, Rx Consultants Group, Inc., and Community Health Centers: Ratify a.) Amendment to the AltaMed Health Services Corporation Fee-For-Service Physician Medi-Cal Contract, reflecting new terms for administration of the COVID-19 vaccine to CalOptima Direct and CalOptima Community Network members; b.) Memorandum of Understanding with Rx Consultants Group, Inc. (Mercy Medical Center Pharmacy), for the provision of COVID-19 vaccines to CalOptima members; and Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Fee-For-Service Physician Medi-Cal Contracts of all Community Health Centers to reflect new terms for administration of the COVID-19 vaccine to CalOptima Direct-Administrative and CalOptima Community Network members, based on their eligibility to administer the vaccine

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Ratify:
    a. Amendment to the AltaMed Health Services Corporation (AltaMed) Fee-For-Service (FFS) Physician Medi-Cal Contract, reflecting new terms for administration of the COVID-19 vaccine to CalOptima Direct (COD) and CalOptima Community Network (CCN) members;
    b. Memorandum of Understanding (MOU) with Rx Consultants Group, Inc. (Mercy Medical Center Pharmacy), for the provision of COVID-19 vaccines to CalOptima members; and
2. Authorize the Chief Executive Officer, (CEO), with the assistance of Legal Counsel, to amend the Fee-For-Service (FFS) Physician Medi-Cal Contracts of all Community Health Centers to reflect new terms for administration of the COVID-19 vaccine to CalOptima Direct-Administrative (COD-A) and CalOptima Community Network (CCN) members, based on their eligibility to administer the vaccine.

Background

On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247) in response to the novel coronavirus, SARS-CoV-2 (COVID-19). Subsequently, on March 13, 2020, the President of the United States declared a national public health emergency based on the spread of COVID-19. CalOptima management has been engaged in ongoing efforts to evaluate and meet providers' and members' needs in mitigating the spread of COVID-19. In compliance with recommendations from federal, state, and local agencies, including the Centers for Disease Control and Prevention and the California Department of Public Health (CDPH), CalOptima has partnered with various providers to implement COVID-19 mitigation strategies and treatments, which now include administering vaccines authorized by the Food and Drug Administration under Emergency Use Authorization.

Back to Agenda

Discussion

As part of an ongoing initiative to provide COVID-19 vaccinations to all CCN, COD and PACE members, CalOptima currently contracts with eligible CalVax providers willing and able to administer the vaccine in cooperation with CDPH and the Orange County public health authorities. Providers includes Mercy Medical Center Pharmacy and Community Health Centers. One such Community Health Center, AltaMed, is a Federally Qualified Health Center (FQHC) authorized to administer COVID-19 vaccinations in cooperation with State and County public health authorities. AltaMed has been administering COVID-19 vaccines to CalOptima COD and CCN members who meet eligibility criteria and compliant with applicable registration and scheduling requirements. AltaMed is authorized to administer the vaccine to COD and CCN members regardless of whether the members are assigned to AltaMed.

To provide COVID-19 vaccinations to CalOptima's COD and CCN population, amendments were made to AltaMed's Fee-For-Service (FFS) Physician Medi-Cal contract, effective February 22, 2021, and include:

- Requirements to forward COVID-19 vaccination claims to the California Department of Health Care Services (DHCS) and accept compensation from the DHCS as payment in full;
- Provision of weekly reports to CalOptima identifying members who have received vaccinations and other related vaccination information;
- CalOptima's responsibility to perform outreach to eligible COD and CCN members, and coordinate member referrals to AltaMed for the scheduling of COVID-19 vaccinations.

In an effort to provide COVID-19 vaccinations to its PACE members, CalOptima entered into an MOU with Mercy Medical Center Pharmacy. This pharmacy has provided on-site COVID-19 vaccinations to both PACE members and staff in accordance with all state regulatory requirements. In addition, Mercy Medical Center Pharmacy has agreed to expand vaccinations to additional CalOptima members and vaccination locations. To continue providing COVID-19 vaccinations to more members, CalOptima plans to engage additional Community Health Centers that are eligible and able to provide vaccinations in compliance with state and local regulations.

For the purpose of vaccinations that have been administered to members, as well as continuing coordination of the COVID-19 vaccination service, staff requests that the CalOptima Board of Directors ratify the amendment to AltaMed's FFS Physician Medi-Cal contract as well as the MOU with Mercy Medical Center Pharmacy. Staff also requests authorization to amend the contracts with other eligible Community Health Centers for the provision of COVID-19 vaccinations for CalOptima COD and CCN members.

Fiscal Impact

The recommended actions to ratify an amendment to the AltaMed FFS Physician Medi-Cal Contract and an MOU with Mercy Medical Center Pharmacy, and to authorize amendment of the contracts of all eligible Community Health Centers to provide COVID-19 vaccinations to COD and CCN members have no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020–21 Operating Budget.

Back to Agenda

Pursuant to the DHCS All Plan Letter 20-022, COVID-19 vaccines and associated administration fees are carved-out from the Medi-Cal managed care delivery system.

Rationale for Recommendation

Ratifying the amendment to AltaMed's FFS Physician Medi-Cal contract and the MOU with Mercy Medical Center Pharmacy, as well as authorizing amendments to the contracts with eligible Community Health Centers to provide COVID-19 vaccinations is expected to increase coordination of COVID-19 vaccination for members in underserved populations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS APL 20-022: COVID-19 Vaccine Administration
2. AltaMed Contract Amendment (Signed)
3. Memorandum of Understanding with Rx Consultants Group, Inc. for COVID-19 Vaccination
4. Template: Amendment to Professional Services Contract

/s/ Richard Sanchez — *03/24/2021*

Authorized Signature — **Date**

Back to Agenda

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: December 28, 2020

ALL PLAN LETTER 20-022

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COVID-19 VACCINE ADMINISTRATION

PURPOSE: The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information and guidance regarding COVID-19 vaccine coverage and administration in the Medi-Cal program.

BACKGROUND:
With the recent federal approval of COVID-19 vaccines, the Department of Health Care Services (DHCS) is seeking federal approval to help support delivery of the vaccines to all Medi-Cal beneficiaries. The vaccines will be provided at no cost to all beneficiaries.

DHCS will be following California's COVID-19 vaccination plan, which was approved by the California Department of Public Health (CDPH). This vaccination plan calls for implementation in several phases: pre-vaccine; limited doses available; larger number of doses available; and sufficient supply of doses available for the entire population.[1]

California is leveraging its existing immunization framework and emergency response infrastructure to coordinate efforts between state, local, and territorial authorities to administer the vaccines. Throughout this effort, DHCS will be sharing appropriate information with providers, MCP partners, other key stakeholders, and Medi-Cal beneficiaries.

Consistent with the approach being taken by Medicare through Medicare Advantage Plans, DHCS will carve out the COVID-19 vaccines and associated administration fees from the Medi-Cal managed care delivery system and will reimburse providers under Medi-Cal fee-for-service (FFS) for medical, pharmacy, and outpatient claims. This approach will ease program administration, eliminate challenges with out-of-network provider reimbursements, and keep vaccine administration fee rates consistent for providers regardless of delivery system.

[1] For further information on the state's vaccination planning efforts please visit: https://covid19.ca.gov/vaccines/

As the federal government will pay for the initial vaccines, there will be no Medi-Cal provider reimbursement for the COVID-19 vaccines themselves. However, providers will be able to bill Medi-Cal FFS for the COVID-19 vaccine administration fees.

DHCS is seeking federal approval to pay pharmacy claims at the Medicare administration rate, which is different than Medi-Cal's current pharmacy administration fee. Subject to federal approval, Medi-Cal will reimburse the associated COVID-19 vaccine administration fees at the allowable Medicare rate for all claims (medical, pharmacy and outpatient) based on the number of required doses, regardless of vaccine manufacturer.

DHCS is also seeking federal approvals to pay Federally Qualified Health Centers, Rural Health Centers, and Tribal 638 clinics for the vaccine administration fees outside of their current Prospective Payment System or All Inclusive Rate.

DHCS continues to closely monitor and respond to COVID-19, and is providing information, including Medi-Cal Newsflashes, on the COVID-19 Medi-Cal response webpage to all providers as a reminder of recommended safety procedures and protocols from the Centers for Disease Control and Prevention (CDC) and CDPH to help prevent spread of COVID-19. DHCS will be issuing initial and future policy guidance on COVID-19 vaccine administration and reimbursement, as necessary. Policy and reimbursement guidance will also be updated, as necessary, upon receipt of additional guidance from the Centers of Medicare & Medicaid Services and/or approvals of requested federal waivers. MCPs and providers are encouraged to continually check this COVID-19 Medi-Cal response webpage for information and regular updates to the Medi-Cal response to COVID-19.[2]

DHCS will also be providing call center scripts for DHCS operated call centers, the Medi-Nurse Advice Line and MCP and county partners so all are providing consistent messaging regarding the COVID-19 vaccine roll-out in Medi-Cal.

Additional Information

Pharmacies, retail clinics, providers, and any other sites of care must sign an agreement with the U.S. government to receive free supplies of the COVID-19 vaccines.

Under the agreement, all providers must vaccinate individuals regardless of existing health coverage or the type of coverage. Providers are prohibited from balance billing or otherwise charging vaccine recipients.

[2] The COVID-19 Medi-Cal Response webpage can be accessed at the following link: https://files.medi-cal.ca.gov/pubsdoco/COVID19_response.aspx

Enrollment in California's COVID-19 Vaccination Program will occur in phases and local health departments (LHD) will invite providers to enroll based on CDPH Allocation Guideline phases and vaccine availability. Enrollment is limited at this time to providers who are authorized by their LHDs. Others may enroll later in January 2021, as vaccine supplies increase. Before enrolling, providers must obtain an immunization information system (IIS) ID.[3] Once providers have been invited by their LHDs and have an IIS ID, they should ensure that they meet all program requirements prior to enrollment.[4] Providers with questions about enrolling in the California COVID-19 Vaccination Program can email COVIDCallCenter@cdph.ca.gov or call (833) 502-1245, Monday through Friday, from 9 a.m. to 5 p.m.

Vaccine recipients must be provided with emergency use authorization fact sheets about the vaccines and vaccination cards identifying the brand of vaccine administered and the date of their second vaccination (if applicable).

Providers must administer the vaccines in accordance with the CDC and Advisory Committee on Immunization Practices requirements, and they must meet storage and recordkeeping requirements, including recording the administration of the vaccines to patients in their own systems within 24 hours and to public health data systems within 72 hours.

Providers will be expected to bill Medi-Cal FFS for COVID-19 vaccine administration using the claim forms and electronic media used today, unless otherwise noted. Billing specifics for the different provider communities and program areas will be released in Medi-Cal Newsflashes. Providers are encouraged to continually check the COVID-19 Medi-Cal response webpage for information and regular updates to the Medi-Cal response to COVID-19.

POLICY:
Although both the COVID-19 vaccines and associated administration fees will be carved out of the Medi-Cal managed care delivery system to Medi-Cal FFS, MCPs are reminded that they remain contractually responsible for providing case management and care coordination for their members regardless of whether or not they are financially responsible for the payment of services.

MCPs are encouraged to identify opportunities to use their existing communication pathways to support dissemination of CDPH COVID-19 public health education materials and provider education resources. MCPs should utilize their existing data

[3] The California Immunization Registry is available at: http://cairweb.org/join-cair/
[4] Action steps and instructions for providers can be found at: https://eziz.org/assets/other/IMM-1295.pdf

sources to help identify members who qualify to receive the COVID-19 vaccine in accordance with CDPH guidelines, and attempt outreach to qualifying members and their providers to encourage receipt of the COVID-19 vaccines. MCPs are responsible for coordinating medically necessary care. Care coordination may involve but is not limited to, assisting members with accessing COVID-19 vaccine administration locations, including providing non-emergency medical transportation and non-medical transportation as needed, and helping members receive the required number of doses for the COVID-19 vaccines in a timely fashion.

As mentioned above, DHCS will be issuing guidance on COVID-19 vaccine administration and reimbursement policies and will be providing call center scripts for MCP use, on a rolling basis. MCPs must ensure they convey relevant and current information on the COVID-19 vaccines to members, including the use of any customer call center scripts or other communications authorized for use by DHCS. MCPs should encourage providers to communicate with members about vaccination availability as such information is made available.

MCPs must also ensure that their Network Providers are following guidance issued by DHCS related to the administration of the COVID-19 vaccines. MCPs are encouraged to disseminate information about the administration of the COVID-19 vaccines to their Network Providers and provide any available resources and information as it becomes available from the CDC, DHCS, CDPH, and other state departments. MCPs are encouraged to continually check the COVID-19 Medi-Cal response webpage for information and regular updates to the Medi-Cal response to COVID-19.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[5] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

[5] For more information on Network Providers and Subcontractors, including the definition and requirements applicable see APL 19-001, and any subsequent APLs on this topic. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

AMENDMENT X TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT X TO THE PROFESSIONAL SERVICES CONTRACT FOR HEALTH CARE SERVICES ("Amendment X") is effective as of February 22, 2021, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), the county organized health system for the County of Orange, California, and AltaMed Health Services Corporation ("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional have entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. The rapid spread of the COVID-19 virus led to state and federal public health emergency ("PHE") declarations.

C. The State of California ("State") is allocating COVID-19 vaccines, currently authorized by the FDA for emergency use under Emergency Use Authorizations ("EUAs"), as they become available to ensure equitable distribution and prioritizing based on age and risk. CalOptima seeks to provide its members with timely access to COVID-19 vaccinations as they become eligible.

D. Professional is authorized to administer COVID-19 vaccinations and does so in cooperation with state and county public health authorities.

E. CalOptima wishes to enter into an arrangement with Professional whereby Professional will administer COVID-19 vaccinations to CalOptima Direct Members, and Professional wishes to provide such services to CalOptima Direct Members, as appropriate.

NOW, THEREFORE, the parties agree as follows:

1. Article 4 shall be added to Attachment A, "CONTRACTED SERVICES", to read as follows:

ARTICLE 4
COD COVID-19 VACCINATION

1. For the duration of the State COVID-19 PHE, and as COVID-19 vaccines are made available to it, Professional shall administer COVID-19 vaccines authorized by the FDA under EUAs (and/or FDA-approved vaccines if, and when, they are available) to CalOptima Direct Members who meet the then-current requirements to receive such vaccinations, and comply with any necessary registration and scheduling requirements applicable to such vaccinations, regardless of whether the Member has Professional as his or her assigned Primary Care Provider.

2. Professional shall file appropriate claims for such vaccinations with the California Department of Health Care Services, and shall accept the compensation provided pursuant to such claims as payment in full for such vaccinations.

3. Professional shall not seek any compensation for the vaccinations covered by this Article from CalOptima, or any CalOptima Direct Member.

4. Professional shall comply with required State COVID-19 vaccination reporting for vaccinations administered to CalOptima Direct Members.

Back to Agenda Back to Item

5. Professional shall provide weekly reports to CalOptima identifying the CalOptima Members receiving COVID-19 vaccinations from Professional and other related vaccination information.

6. CalOptima shall provide outreach to eligible CalOptima Direct Members regarding Professional's vaccination services as described herein, and will coordinate referrals of Members to Professional for scheduling COVID-19 vaccinations.

7. Either CalOptima or Professional may terminate the arrangement described in this Article 4 by providing thirty (30) days written notice to the other party.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and AltaMed Health Services Corporation have executed this Amendment X.

FOR PROFESSIONAL:

SIGNATURE

José U. Esparza
PRINT NAME

SVP Finance & CFO
TITLE

3/3/2021
DATE

FOR CALOPTIMA:

SIGNATURE

Ladan Khamseh
PRINTNAME

Chief Operating Officer
TITLE

3/4/2021
DATE

Back to Agenda Back to Item

Memorandum Of Understanding
For
Covid-19 Vaccination

Back to Agenda Back to Item

This Memorandum of Understanding (this "Agreement") is entered into as of contract start date by and between the Orange County Health Authority, a local public agency, dba CalOptima ("CalOptima") and RX Consultants Group, Inc., dba Mercy Medical Center Pharmacy, a California corporation ("the Pharmacy") (also sometimes individually referred to as "Party" and collectively as "Parties).

I. RECITALS:

WHEREAS, the Program of All-Inclusive Care for the Elderly ("PACE") provides comprehensive services for persons eligible for both Medicare and Medi-Cal who are eligible for long-term care in a skilled nursing facility for the purpose of allowing such persons to safely remain in their homes.

WHEREAS, CalOptima operates a PACE program site at the CalOptima PACE Center ("Center") located at 13300 Garden Grove Blvd., Garden Grove, California.

WHEREAS, the Pharmacy is a full-service retail pharmacy, duly licensed in the State of California .

WHEREAS, the rapid spread of the COVID-19 virus led to state and federal public health emergency ("PHE") declarations.

WHEREAS, the State of California ("State") is allocating COVID-19 vaccines, currently authorized by the FDA for emergency use under Emergency Use Authorizations ("EUAs"), as they become available to ensure equitable distribution and prioritizing based on age and risk.

WHEREAS, CalOptima wishes to enter into an arrangement with Pharmacy whereby Pharmacy will administer COVID-19 vaccinations to eligible PACE Members at the CalOptima PACE Center.

WHEREAS, the Pharmacy is authorized to administer COVID-19 vaccinations and does so in cooperation with state and county public health authorities. The Pharmacy has contracted with _____ to administer COVID-19 vaccinations to eligible persons.

WHEREAS, the Pharmacy is willing and able to administer COVID-19 vaccinations to CalOptima PACE members at the PACE Center ("COVID-19 vaccination services").

II. AGREEMENT:

1. OBLIGATIONS OF CALOPTIMA

CalOptima will undertake the following actions:

1. Inform its staff of the Pharmacy's COVID-19 vaccination services and facilitate the communication between its staff and the Pharmacy. In addition, CalOptima will confirm an accurate headcount of willing PACE participants as soon as possible and at least seven (7) days prior to the scheduled COVID-19 vaccination clinic dates.

2. Provide adequate facilities for administration of the COVID-19 vaccines (proper outdoor set-up or a well-ventilated room with separate entry and exit flow, parking, tables, tents, internet access and any applicable tools to set up vaccination clinics).

3. Provide support staff to assist with logistics/set-up of the COVID-19 vaccination clinic, registration, parking monitoring, patient assistance, and clean-up on the days of vaccination.

4. Secure COVID-19 vaccine doses from the Orange County Health Care Agency ("OCHA") for its staff.

CalOptima agrees to abide by all federal and state-specific licensure requirements to operate its PACE Center facility and to provide documentation to the Pharmacy of such information.

2. OBLIGATIONS OF THE PHARMACY

The Pharmacy shall provide on-site COVID-19 vaccination clinic to CalOptima's staff once the COVID-19 vaccine is allocated to the Center by the OCHCA.

The Pharmacy shall comply with all necessary PACE Center Management requirements if deemed appropriate by CalOptima to establish itself as a vendor, receive badging, and provide evidence of required immunizations, licenses, and drug screens if required.

The Pharmacy agrees to abide by all state-specific medication distribution, counseling, administration and any other services with licensure requirements and documentation to CalOptima of such information.

The Pharmacy will ensure medication integrity and safety during transportation, storage, and administration of the COVID-19 vaccine.

The Pharmacy may withhold dispensing and administration of the COVID-19 vaccine to a particular patient if there is any medical contraindication or justification, as determined by the Pharmacy.

The Pharmacy will collect and remove at their expense all medical waste, including but not limited to sharps, gloves, masks, gowns, containers, other medical supplies. Medical Waste cannot be disposed of on PACE Center property

In measuring the Pharmacy's attainment of such performance expectations, the Pharmacy will not be responsible for delays if the Pharmacy receives materials from CalOptima less than 72 hours prior to service date, or experiences delays caused by power outages, lack of wireless connectivity or other unforeseeable technical circumstances.

Based on census data collected by CalOptima indicating that approximately 310 PACE Center Members wish to participate in the PACE Center COVID-19 vaccine clinic, the Pharmacy agrees to conduct a total of 4 vaccine clinics ranging from 4-8 hours, mutually agreed upon by parties to accommodate the total vaccine appointments at the PACE Center. This will include 2 days for dose 1 and 2 days for dose 2. The Pharmacy and PACE Center will coordinate to ensure the PACE Center vaccination clinics provide sufficient dates and times for all designated PACE Members to receive both doses of the COVID-19 vaccine. In addition, the parties may mutually agree upon additional CalOptima populations and vaccination locations.

The Pharmacy shall ensure that, in administering COVID-19 vaccines under this Agreement, it complies with the requirements of the CalOptima Regulatory Exhibit attached to the

Pharmacy's Participating Pharmacy Agreement with MedImpact.

3. TERMS AND TERMINATION

Either Party may terminate this Agreement at any time, with or without cause, by giving at least fourteen (14) days prior written notice to the other Party.

4. INDEMNIFICATION

CalOptima shall defend, indemnify and hold the Pharmacy, its members, directors, officers, agents and/or employees harmless from and against any and all claims, demands, assessments, judgments, damages, losses, actions, penalties, fines, liabilities, encumbrances, liens, costs and expenses of investigation and defense of any claim, whether or not such claim is ultimately defeated, and of any good faith settlement of judgment, of whatever kind or nature including, but not limited to, reasonable attorneys' fees and disbursements, arising out of, in connection with or otherwise resulting from, any act or omission of CalOptima, its officers, agents, or employees (other than the Pharmacy and its officers, agents, or employees). Upon notice from the Pharmacy, CalOptima, at its expense, shall resist and defend any such claim or action by counsel reasonably satisfactory to the Pharmacy.

The Pharmacy shall defend, indemnify and hold CalOptima, its directors, officers, agents and/or employees harmless from and against any and all claims, demands, assessments, judgments, damages, losses, actions, penalties, fines, liabilities, encumbrances, liens, costs and expenses of investigation and defense of any claim, whether or not such claim is ultimately defeated, and of any good faith settlement of judgment, of whatever kind or nature including, but not limited to, reasonable attorneys' fees and disbursements, arising out of, in connection with or otherwise resulting from, any act or omission of the Pharmacy, its officers, agents, or employees (other than CalOptima and its officers, agents, or employees). Upon notice from CalOptima, the Pharmacy, at the Pharmacy's expense, shall resist and defend any such claim or action by counsel reasonably satisfactory to CalOptima.

The Parties agree to carry Workers Compensation in statutory amounts, Employer's liability Insurance and Commercial General Liability Insurance each in the amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate. In addition, the Pharmacy agrees to carry professional liability insurance in the amount no less than $1,000,000 per occurrence and $3,000,000 in aggregate.

5. COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

It is the intent of the Parties that the terms of this Agreement be in compliance with all applicable federal and state laws, statutes, rules and regulations, including, without limitation, Medicare and Medicaid fraud and abuse and Stark law provisions.

If either Party determines, in good faith, or receives general or specific notice from a governmental agency that this Agreement or any part hereof: (I) violates or fails to comply with any state or federal law, regulation, rule or administrative policy or would result in Stark law restrictions on referrals to the Center or any of its affiliates; (ii) jeopardizes such Party's (or any

of its affiliates') participation in any federal or state health care program; or (iii) exposes any person or Party or its affiliates to any other sanctions by any other regulatory agency, such Party shall notify the other Party in writing of its determination. The Parties shall then (i) negotiate those modifications reasonably determined to be necessary to comply with a change of law or other event described in this Section; or (ii) if the Parties are unable to negotiate a modification within thirty (30) days of delivery of the notice, then this Agreement shall automatically terminate.

The Parties agree that it is not their intention to limit or reduce items or services to CalOptima PACE Members. Instead, it is the Parties' intention to improve the quality, efficiency and effectiveness of the provision of care to the PACE Members.

The Pharmacy agrees to conduct its activities in accordance with all laws and regulations applicable to the COVID-19 vaccination services required hereunder.

6. HIPAA

With respect to any patient or medical record information regarding PACE Members, Pharmacy shall comply with all federal and state privacy laws and regulations, and all bylaws, rules, regulations, and policies of CalOptima and its medical staff, regarding the confidentiality of such information, including, without limitation, all applicable provisions and regulations of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

7. Independent Contractor

At all times during the term of this Agreement, it is agreed that each Party is acting as an independent contractor and not as an agent or employee of the other Party. To the extent applicable to it, each Party agrees to pay as they become due all federal and state income taxes as well as all other taxes due and payable on the compensation earned by such Party hereunder.

8. Excluded Provider

Each Party represents and warrants to the other that it, its officers, directors, agents and all representative(s) (i) are not currently excluded, debarred, on the Medi-Cal Suspended and Ineligible Provider list or the CMS Preclusion List or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. Section l320a-7b(t) (the "Federal healthcare programs"); (ii) are not convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal healthcare programs; and (iii) are not under investigation or otherwise aware of any circumstances which may result in such Party being excluded from participation in the Federal healthcare programs. This shall be an ongoing representation and warranty during the term of this Agreement and such Party shall immediately notify the other Party of any change in the status of the representation and warranty set forth in this section.

Any breach of this section shall give the non-breaching Party the right to terminate this Agreement immediately for cause.

9. No Liability of the County of Orange

As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Pharmacy hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

10. Severability

If any term, covenant, or condition of this Agreement or the application thereof to any person or circumstance shall be invalid or unenforceable, the remainder of this Agreement and the application of any term or provision to person or circumstances other than those to which it is held invalid or unenforceable shall not be affected thereby and all other terms shall be valid and enforceable to the fullest extent permitted by law.

11. Amendment Binding Effect

This Agreement may not be modified except in writing executed by both Parties. This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and permitted assigns.

In Witness Whereof, the duly authorized officer and representative of CalOptima and the Pharmacy have executed this Agreement on the dates as indicated below.

Orange County Health Authority dba CalOptima
By:_____
Title:_____
Date:_____

RX Consultants Group, Inc., dba Mercy Medical Center Pharmacy, a California Corporation
By:_____
Title:_____
Date:_____

AMENDMENT _ TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT __ TO THE PROFESSIONAL SERVICES CONTRACT FOR HEALTH CARE SERVICES ("Amendment __ ") is effective as of_____, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), the county organized health system for the County of Orange, California, and ____("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional have entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. The rapid spread of the COVID-19 virus led to state and federal public health emergency ("PHE") declarations.

C. The State of California ("State") is allocating COVID-19 vaccines, currently authorized by the FDA for emergency use under Emergency Use Authorizations ("EUAs"), as they become available to ensure equitable distribution and prioritizing based on age and risk. CalOptima seeks to provide its members with timely access to COVID-19 vaccinations as they become eligible.

D. Professional is authorized to administer COVID-19 vaccinations and does so in cooperation with state and county public health authorities.

E. CalOptima wishes to enter into an arrangement with Professional whereby Professional will administer COVID-19 vaccinations to CalOptima Direct Members, and Professional wishes to provide such services to CalOptima Direct Members, as appropriate.

NOW, THEREFORE, the parties agree as follows:

1. Article 4 shall be added to Attachment A, "CONTRACTED SERVICES", to read as follows:

ARTICLE 4
COD COVID-19 VACCINATION

1. For the duration of the State COVID-19 PHE, and as COVID-19 vaccines are made available to it, Professional shall administer COVID-19 vaccines authorized by the FDA under EUAs (and/or FDA-approved vaccines if, and when, they are available) to CalOptima Direct Members who meet the then-current requirements to receive such vaccinations, and comply with any necessary registration and scheduling requirements applicable to such vaccinations, regardless of whether the Member has Professional as his or her assigned Primary Care Provider.

2. Professional shall file appropriate claims for such vaccinations with the California Department of Health Care Services, and shall accept the compensation provided pursuant to such claims as payment in full for such vaccinations.

3. Professional shall not seek any compensation for the vaccinations covered by this Article from CalOptima, or any CalOptima Direct Member.

4. Professional shall comply with required State COVID-19 vaccination reporting for vaccinations administered to CalOptima Direct Members.

5. Professional shall provide weekly reports to CalOptima identifying the CalOptima Members receiving COVID-19 vaccinations from Professional and other related vaccination information.

6. CalOptima shall provide outreach to eligible CalOptima Direct Members regarding Professional's vaccination services as described herein, and will coordinate referrals of Members to Professional for scheduling COVID-19 vaccinations.

7. Either CalOptima or Professional may terminate the arrangement described in this Article 4 by providing thirty (30) days written notice to the other party.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment _.

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_Ladan Khamseh_____
PRINT NAME	PRINTNAME
_____	_Chief Operating Officer_____
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event: Authorize expenditures up to $10,000 for Age Well Senior Services, Inc. Virtual Senior Summit 2021 "Safe and Healthy Senior Living in the Age of COVID-19" in May 2021; Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    a. Up to $10,000 for Age Well Senior Services, Inc. Virtual Senior Summit 2021 "Safe and Healthy Senior Living in the Age of COVID-19" in May 2021.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the community outreach and education benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to limit professional, social and community gatherings outside of a list of "essential activities." As a result, CalOptima staff is not currently attending any-in person community events, health and resource fairs, town halls, workshops, or other public activities while the stay-at-home orders are in effect. Additionally, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19.

Back to Agenda

CalOptima staff recognizes the unprecedented health and economic challenges our community partners and members are experiencing due to the COVID-19 and understand the importance of supporting our community partners who are serving our members during this pandemic.

Discussion

The recommended event will provide CalOptima with opportunities to conduct outreach and education to current and potential members who are older adults, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

a. **Age Well Senior Services Virtual Senior Summit 2021**
   Staff recommends authorization of expenditures for participation in the Virtual Senior Summit 2021. This virtual event will be held in partnership with the Orange County (OC) Office on Aging and will be presented during the month of May, which is recognized as Older Adult Americans month. The theme of this virtual event is "Safe and Healthy Senior Living in the Age of COVID-19" and will feature presentations by the OC Office on Aging, Saddleback College Emeritus Institute, University of California, Irvine, Supervisor Lisa Bartlett, and Dr. Clayton Chau, County Health Officer and Director of Orange County Health Care Agency, who also serves on CalOptima's Board of Directors. Presentations will discuss the impacts of COVID on the older adult population and ways to live healthy, safe, and happy lives during these challenging times.

CalOptima has sponsored the event for eleven years and has sponsored the event at the $10,000 level for the past five years. Staff recommends CalOptima's continued support for this event in virtual format with a $10,000 financial commitment for 2021, which includes the following: Opportunity for CalOptima leadership to present as a keynote speaker; CalOptima animated 'explainer' videos for seniors on issues related to COVID-19, safety and vaccines; company logo on all event marketing and direct mail, which includes 150,000+ oversized postcards mailed to South County households, 200,000+ digital fliers emailed to South County residents; and recognition during the pre-recorded event. The event will be televised on COX Communications Channel 39 at 8am and 6 pm every day in the month of May, as well as on social media platforms, including YouTube and Facebook. Sponsorship benefits from past in-person events included an opportunity for CalOptima's leadership to present, an on-stage award recognition at the event and company logo on marketing materials and event background. This will be CalOptima's twelfth year sponsoring the event, with last year's event being cancelled due to the COVID-19 pandemic. The last in-person event in 2019 drew over 1,600 attendees.

This televised event in 2021 will provide an opportunity to increase CalOptima's visibility in the older adult community and may reach a larger audience given this virtual platform. Event organizers anticipate that tens of thousands of older adults, in addition to their caretakers and family members are expected to view this televised event, given the topic and impact of COVID on older adults. Other community events have transitioned to a virtual platform during COVID-19 and have reported similar or greater attendance over prior in-person events. This is an educational event that will provide an opportunity for outreach and education about CalOptima's programs and services for older adults residing in South County, who may be in need of CalOptima and Medi-Cal services, as well as others who care for them.

Back to Agenda

CalOptima staff reviewed the request, and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate CalOptima's information and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item is based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $10,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2020-21 Operating Budget approved by the CalOptima Board of Directors on June 4, 2020.

Rationale for Recommendation

Staff recommends approval of the recommended actions in response to the COVID-19 pandemic as an opportunity to educate the community, specifically older adults about CalOptima and the Medi-Cal program and the healthcare services CalOptima makes available in support of our community partners.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Sponsorship Request from Age Well Senior Services Virtual Senior Summit 2021

/s/ Richard Sanchez *03/24/2021*
Authorized Signature **Date**

Back to Agenda

Attachment to the April 1, 2021 Board of Directors Meeting – Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Age Well Senior Services, Inc.	24461 Ridge Route Dr., Suite 220	Laguna Niguel	CA	92653

Back to Agenda Back to Item

Case Management
In-Home Care Support
Meals on Wheels

Tel: (949) 855-8033

Age Well® Senior Services
A NONPROFIT SERVING ORANGE COUNTY'S SENIORS

Nutritional Services
Senior Centers
Transportation
Volunteer Opportunities

Fax: (949) 855-8025

February 24, 2021

Dear CalOptima,

As the lead sponsoring nonprofit agency, Age Well Senior Services, Inc. cordially invites you to support the Virtual South County Senior Summit 2021. In previous years, CalOptima has sponsored this event at the $10,000 level, and we are hopeful you will consider doing so once again.

Due to the ongoing coronavirus pandemic, this very popular annual event will be presented virtually by OC Supervisor Lisa Bartlett in partnership with the OC Office on Aging and Age Well Senior Services. The 2021 Virtual Senior Summit will be presented during the month of May - nationally recognized as Older Adult Americans Month - on COX Communications Channel 39 at 8:00 AM and 6:00 PM, as well as on social media platforms, including YouTube and Facebook.

The prerecorded program will feature a high-profile panel of experts providing timely presentations related to our theme: *"**Safe and Healthy Senior Living in the Age of COVID-19.**"* In addition to Supervisor Bartlett, other featured speakers currently include Dr. Clayton Chau (County Health Officer), OC Office on Aging, Age Well Senior Services, Saddleback College Emeritus Institute, and UC Irvine,

As such, the 2021 Virtual South County Senior Summit will present the impacts COVID-19 has had on our older adult population, as well as how seniors can continue living safely, healthy and happily during these challenging and unprecedented times. To that end, tens of thousands of older adults, in addition to their caretakers and concerned family members, are expected to tune-in to this important event!

As in past years, by becoming a $10,000 Presenting Sponsor of the 2021 Senior Summit, CalOptima will again be recognized by Supervisor Lisa Bartlett during the program. In addition to having a keynote speaking role, CalOptima's presentation may also include an animated short explainer video for seniors regarding COVID-19 vaccinations, plus your logo will be prominently featured on all event marketing and direct mail, which includes 150,000+ oversized postcards mailed to South County households, as well as 200,000+ digital flyers emailed to 5th District constituents on a weekly basis leading to the event.

To that end, CalOptima's $10,000 sponsorship will help us to defray the cost of the direct mail piece, including postage, in addition to the production costs to tape and televise this month-long virtual event. Moreover, your ***tax-deductible*** donation will not only support the 2021 Virtual Senior Summit, but your organization will benefit greatly from this unique opportunity to connect with tens of thousands of older adults while continuing to demonstrate your care and concern for them.

To become a Presenting Sponsor of the Virtual South County Senior Summit, please return the attached Sponsor Pledge Form by Friday, April 2, 2021. Thank you for your kind consideration!

Sincerely,

Steve Moyer
Chief Executive Officer
Age Well Senior Services, Inc.

Back to Agenda Back to Item

A Public Agency

CalOptima

Better. Together.

Financial Summary

February 28, 2021

Board of Directors Meeting

April 1, 2021

Nancy Huang, Chief Financial Officer

Back to Agenda

FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $11.8 million, favorable to budget $5.9 million or 101.6%
  - YTD: $25.7 million, favorable to budget $35.9 million or 353.0%
- Enrollment
  - MTD: 810,105 members, favorable to budget 668 or 0.1%
  - YTD: 6,375,931 member months, favorable to budget 29,889 or 0.5%
- Revenue
  - MTD: $324.9 million, favorable to budget $55.2 million or 20.4% driven by Medi-Cal (MC) line of business (LOB):
    - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
    - $7.1 million of prior period revenue due to retroactivity
    - Offset by $9.1 million due to the Bridge Period Gross Medical Expenditures (GME) risk corridor and Proposition 56 risk corridor reserve
  - YTD: $2.6 billion, favorable to budget $138.9 million or 5.6% driven by MC LOB:
    - Fiscal Year (FY) 2019 hospital Directed Payments (DP) and the pharmacy benefit transition postponement
    - Offset by the Bridge Period GME risk corridor and Proposition 56 risk corridor reserve

Back to Agenda

CalOptima
A Public Agency

FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $302.7 million, unfavorable to budget $49.7 million or 19.6%
    - Driven by MC LOB $50.0 million unfavorable variance due to postponement of pharmacy benefit transition, offset by decreased utilization during COVID-19 pandemic and release of prior year Neonatal Intensive Care Unit (NICU) accruals
  - YTD: $2.5 billion, unfavorable to budget $109.1 million or 4.6%
    - Driven by MC LOB FY 2019 hospital DP and pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic
    - OCC LOB unfavorable to budget $14.2 million or 7.1%
- Administrative Expenses
  - MTD: $11.1 million, favorable to budget $1.0 million or 8.4%
  - YTD: $89.1 million, favorable to budget $11.4 million or 11.3%
- Net Investment & Other Income
  - MTD: $0.7 million, unfavorable to budget $0.6 million or 44.0%
  - YTD: $4.6 million, unfavorable to budget $5.4 million or 53.7% primarily due to $7.2 million of unrealized loss on investments

Back to Agenda

CalOptima A Public Agency

FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 93.2%, Budget 93.8%
  - YTD: Actual 95.8% (99.7% excluding DP), Budget 96.7%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.4%, Budget 4.5%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 4.1%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.91
  - Net position: $1.1 billion, including required Tangible Net Equity (TNE) of $102.9 million

Back to Agenda

CalOptima
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Enrollment Summary: February 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
107,949	111,051	(3,102)	(2.8%)	SPD	915,581	887,317	28,264	3.2%
517	468	49	10.5%	BCCTP	4,117	3,838	279	7.3%
294,933	317,408	(22,475)	(7.1%)	TANF Child	2,335,194	2,472,905	(137,711)	(5.6%)
102,882	95,389	7,493	7.9%	TANF Adult	791,488	743,639	47,849	6.4%
3,007	3,519	(512)	(14.5%)	LTC	25,962	28,096	(2,134)	(7.6%)
272,590	253,901	18,689	7.4%	MCE	2,078,356	1,988,079	90,277	4.5%
11,622	11,931	(309)	(2.6%)	WCM	92,103	95,453	(3,350)	(3.5%)
793,500	**793,667**	**(167)**	**(0.0%)**	**Medi-Cal Total**	**6,242,801**	**6,219,327**	**23,474**	**0.4%**
14,569	**13,948**	**621**	**4.5%**	**OneCare Connect**	**117,270**	**112,326**	**4,944**	**4.4%**
1,645	**1,378**	**267**	**19.4%**	**OneCare**	**12,763**	**11,024**	**1,739**	**15.8%**
391	**444**	**(53)**	**(11.9%)**	**PACE**	**3,097**	**3,365**	**(268)**	**(8.0%)**
810,105	**809,437**	**668**	**0.1%**	**CalOptima Total**	**6,375,931**	**6,346,042**	**29,889**	**0.5%**

Back to Agenda

CalOptima
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Financial Highlights: February 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
810,105	809,437	668	0.1%	Member Months	6,375,931	6,346,042	29,889	0.5%
324,938,441	269,786,441	55,152,000	20.4%	Revenues	2,608,924,280	2,469,975,258	138,949,022	5.6%
302,716,555	253,032,602	(49,683,953)	(19.6%)	Medical Expenses	2,498,687,136	2,389,612,122	(109,075,014)	(4.6%)
11,141,769	12,160,576	1,018,807	8.4%	Administrative Expenses	89,125,309	100,534,708	11,409,399	11.3%
11,080,117	**4,593,263**	**6,486,854**	**141.2%**	**Operating Margin**	**21,111,836**	**(20,171,572)**	**41,283,408**	**204.7%**
699,932	1,250,000	(550,068)	(44.0%)	Non Operating Income (Loss)	4,625,455	10,000,000	(5,374,545)	(53.7%)
11,780,049	**5,843,263**	**5,936,786**	**101.6%**	**Change in Net Assets**	**25,737,291**	**(10,171,572)**	**35,908,863**	**353.0%**
93.2%	93.8%	0.6%		Medical Loss Ratio	95.8%	96.7%	1.0%	
3.4%	4.5%	1.1%		Administrative Loss Ratio	3.4%	4.1%	0.7%	
3.4%	1.7%	1.7%		Operating Margin Ratio	0.8%	(0.8%)	1.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.2%	93.8%	0.6%		*MLR (excluding Directed Payments)	99.7%	96.7%	(3.0%)	
3.4%	4.5%	1.1%		*ALR (excluding Directed Payments)	3.6%	4.1%	0.5%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Back to Agenda

CalOptima
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Consolidated Performance Actual vs. Budget: February 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
9.3	4.0	5.3	Medi-Cal	16.6	(15.2)	31.8
1.5	0.2	1.3	OCC	0.1	(6.8)	6.8
(0.1)	0.0	(0.1)	OneCare	0.3	0.2	0.0
0.3	0.4	(0.0)	PACE	4.2	1.6	2.6
11.1	**4.6**	**6.5**	**Operating**	**21.1**	**(20.2)**	**41.3**
0.7	1.3	(0.6)	Inv./Rental Inc, MCO tax	4.6	10.0	(5.4)
0.7	**1.3**	**(0.6)**	**Non-Operating**	**4.6**	**10.0**	**(5.4)**
11.8	**5.8**	**5.9**	**TOTAL**	**25.7**	**(10.2)**	**35.9**

Back to Agenda

CalOptima
A Public Agency

Consolidated Revenue & Expenses: February 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	509,288	272,590	11,622	793,500	14,569	1,645	391	810,105
REVENUES								
Capitation Revenue	149,920,169	$ 120,003,535	$ 23,962,832	$ 293,886,536	$ 25,864,516	$ 1,829,169	$ 3,358,220	$ 324,938,441
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	149,920,169	120,003,535	23,962,832	293,886,536	25,864,516	1,829,169	3,358,220	324,938,441
MEDICAL EXPENSES								
Provider Capitation	47,502,832	47,816,733	18,583,804	113,903,370	9,786,251	501,932		124,191,553
Facilities	24,344,570	24,279,488	(5,620,513)	43,003,545	6,345,891	590,616	1,034,856	50,974,909
Professional Claims	18,958,868	9,291,637	1,238,973	29,489,478	886,047	30,549	599,905	31,005,979
Prescription Drugs	19,164,595	24,751,912	5,730,698	49,647,205	3,424,521	510,434	268,732	53,850,892
MLTSS	28,996,270	2,681,672	1,879,163	33,557,104	1,220,072	43,659	86,036	34,906,871
Medical Management	2,055,256	1,244,310	258,634	3,558,201	1,002,397	31,437	797,219	5,389,253
Quality Incentives	857,939	533,928	35,407	1,427,274	212,640		4,888	1,644,801
Reinsurance & Other	346,145	191,001	11,188	548,334	146,590		57,373	752,297
Total Medical Expenses	142,226,474	110,790,681	22,117,353	275,134,509	23,024,410	1,708,627	2,849,009	302,716,555
Medical Loss Ratio	94.9%	92.3%	92.3%	93.6%	89.0%	93.4%	84.8%	93.2%
GROSS MARGIN	**7,693,695**	**9,212,854**	**1,845,478**	**18,752,027**	**2,840,106**	**120,541**	**509,211**	**22,221,886**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,476,912	661,627	77,230	115,397	7,331,166
Professional fees				222,215	35,468	38,961	123	296,768
Purchased services				909,937	29,930	7,936	10,687	958,491
Printing & Postage				157,767	38,139	7,680	11,747	215,332
Depreciation & Amortization				261,747			2,020	263,767
Other expenses				1,729,300	1,889		17,748	1,748,936
Indirect cost allocation & Occupancy				(318,255)	599,155	42,173	4,237	327,310
Total Administrative Expenses				9,439,622	1,366,208	173,980	161,959	11,141,769
Admin Loss Ratio				3.2%	5.3%	9.5%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				9,312,405	1,473,899	(53,439)	347,253	11,080,117
INVESTMENT INCOME								(372,287)
TOTAL MCO TAX				1,072,204				1,072,204
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 10,384,624**	**$ 1,473,899**	**$ (53,439)**	**$ 347,253**	**$ 11,780,049**
BUDGETED CHANGE IN NET ASSETS				4,012,354	198,408	12,251	370,250	5,843,263
VARIANCE TO BUDGET - FAV (UNFAV)				$ 6,372,270	$ 1,275,491	$ (65,690)	$ (22,997)	$ 5,936,786

Back to Agenda

CalOptima
A Public Agency

Consolidated Revenue & Expenses: February 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,072,342	2,078,356	92,103	6,242,801	117,270	12,763	3,097	6,375,931
REVENUES								
Capitation Revenue	1,216,175,279	$ 939,068,249	$ 185,925,366	$ 2,341,168,895	$ 225,809,302	$ 15,920,228	$ 26,025,856	$ 2,608,924,280
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,216,175,279	939,068,249	185,925,366	2,341,168,895	225,809,302	15,920,228	26,025,856	2,608,924,280
MEDICAL EXPENSES								
Provider Capitation	299,580,594	354,391,582	97,877,745	751,849,921	96,209,345	4,382,244		852,441,510
Facilities	189,713,407	200,412,111	11,987,498	402,113,016	39,729,154	4,201,194	5,259,722	451,303,086
Professional Claims	157,310,804	72,618,657	8,181,237	238,110,699	7,844,189	591,269	4,813,280	251,359,437
Prescription Drugs	158,639,729	199,470,664	41,916,227	400,026,621	47,131,131	4,691,004	2,268,590	454,117,345
MLTSS	267,190,322	22,560,096	15,126,407	304,876,825	11,275,546	241,570	488,093	316,882,035
Medical Management	18,563,278	10,989,997	2,328,972	31,882,248	8,643,259	290,575	6,803,068	47,619,149
Quality Incentives	8,930,921	4,116,314	491,258	13,538,493	1,732,125		123,072	15,393,690
Reinsurance & Other	59,749,229	47,779,941	96,866	107,626,035	1,096,782		848,068	109,570,884
Total Medical Expenses	1,159,678,286	912,339,361	178,006,210	2,250,023,856	213,661,531	14,397,856	20,603,892	2,498,687,136
Medical Loss Ratio	95.4%	97.2%	95.7%	96.1%	94.6%	90.4%	79.2%	95.8%
GROSS MARGIN	**56,496,994**	**26,728,888**	**7,919,157**	**91,145,038**	**12,147,771**	**1,522,372**	**5,421,964**	**110,237,145**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				54,181,804	5,573,914	660,206	927,862	61,343,785
Professional fees				1,025,782	149,030	140,973	1,027	1,316,812
Purchased services				6,430,932	646,154	65,198	128,837	7,271,121
Printing & Postage				1,851,012	637,271	46,649	97,480	2,632,413
Depreciation & Amortization				2,303,648			16,220	2,319,868
Other expenses				11,118,846	258,862	205	37,126	11,415,039
Indirect cost allocation & Occupancy				(2,335,512)	4,793,237	337,386	31,160	2,826,270
Total Administrative Expenses				74,576,513	12,058,468	1,250,617	1,239,711	89,125,309
Admin Loss Ratio				3.2%	5.3%	7.9%	4.8%	3.4%
INCOME (LOSS) FROM OPERATIONS				16,568,525	89,303	271,754	4,182,253	21,111,836
INVESTMENT INCOME								5,114,871
TOTAL MCO TAX				(503,796)				(503,796)
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				330				330
CHANGE IN NET ASSETS				**$ 16,079,109**	**$ 89,303**	**$ 271,754**	**$ 4,182,253**	**$ 25,737,291**
BUDGETED CHANGE IN NET ASSETS				(15,226,078)	(6,760,644)	246,070	1,569,080	(10,171,572)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,305,187	$ 6,849,947	$ 25,684	$ 2,613,173	$ 35,908,863

Back to Agenda

CalOptima
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Balance Sheet: As of February 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$279,220,906	Accounts Payable	$32,810,569
Investments	906,605,655	Medical Claims liability	1,004,888,436
Capitation receivable	378,554,697	Accrued Payroll Liabilities	16,001,111
Receivables - Other	43,761,557	Deferred Revenue	17,647,947
Prepaid expenses	9,038,735	Deferred Lease Obligations	138,682
		Capitation and Withholds	138,485,693
Total Current Assets	**1,617,181,550**	**Total Current Liabilities**	**1,209,972,437**
Capital Assets			
Furniture & Equipment	40,923,636		
Building/Leasehold Improvements	11,375,256		
505 City Parkway West	51,628,218		
	103,927,109		
Less: accumulated depreciation	(57,365,590)		
Capital assets, net	46,561,520	Other (than pensions) post employment benefits liability	26,168,098
Other Assets		Net Pension Liabilities	27,242,277
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,263,382,811**
Cash and Cash Equivalents	(6,396,775)		
Long-term Investments	594,822,393	Deferred Inflows	
Total Board-designated Assets	588,425,618	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
Total Other Assets	645,524,531	Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,309,267,601**	TNE	102,945,259
Deferred Outflows		Funds in Excess of TNE	947,923,329
Contributions	1,047,297	**TOTAL NET POSITION**	1,050,868,588
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,320,928,671**	**DEFERRED INFLOWS & NET POSITION**	**2,320,928,671**

Back to Agenda

CalOptima
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Board Designated Reserve and TNE Analysis: As of February 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,918,099				
	Tier 1 - MetLife	159,938,922				
	Tier 1 - Wells Capital	160,081,210				
Board-designated Reserve		480,938,230	327,710,580	512,277,369	153,227,650	(31,339,138)
TNE Requirement	Tier 2 - MetLife	107,487,388	102,945,259	102,945,259	4,542,129	4,542,129
	Consolidated:	**588,425,618**	**430,655,839**	**615,222,627**	**157,769,779**	**(26,797,009)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

Back to Agenda

CalOptima
A Public Agency

Our Mission

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

Back to Agenda

CalOptima
A Public Agency

UNAUDITED FINANCIAL STATEMENTS

February 28, 2021

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Eight Months Ended February 28, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
810,105	809,437	668	0.1%	Member Months	6,375,931	6,346,042	29,889	0.5%
324,938,441	269,786,441	55,152,000	20.4%	Revenues	2,608,924,280	2,469,975,258	138,949,022	5.6%
302,716,555	253,032,602	(49,683,953)	(19.6%)	Medical Expenses	2,498,687,136	2,389,612,122	(109,075,014)	(4.6%)
11,141,769	12,160,576	1,018,807	8.4%	Administrative Expenses	89,125,309	100,534,708	11,409,399	11.3%
11,080,117	**4,593,263**	**6,486,854**	**141.2%**	**Operating Margin**	**21,111,836**	**(20,171,572)**	**41,283,408**	**204.7%**
699,932	1,250,000	(550,068)	(44.0%)	Non Operating Income (Loss)	4,625,455	10,000,000	(5,374,545)	(53.7%)
11,780,049	**5,843,263**	**5,936,786**	**101.6%**	**Change in Net Assets**	**25,737,291**	**(10,171,572)**	**35,908,863**	**353.0%**
93.2%	93.8%	0.6%		Medical Loss Ratio	95.8%	96.7%	1.0%	
3.4%	4.5%	1.1%		Administrative Loss Ratio	3.4%	4.1%	0.7%	
3.4%	1.7%	1.7%		Operating Margin Ratio	0.8%	(0.8%)	1.6%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
93.2%	93.8%	0.6%		*MLR (excluding Directed Payments)	99.7%	96.7%	(3.0%)	
3.4%	4.5%	1.1%		*ALR (excluding Directed Payments)	3.6%	4.1%	0.5%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Eight Months Ended February 28, 2021

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	793,500	793,667	(167)	(0 0%)
OneCare Connect	14,569	13,948	621	4 5%
OneCare	1,645	1,378	267	19 4%
PACE	391	444	(53)	(11 9%)
Total	810,105	809,437	668	0 1%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,385	$ 4,012	$ 6,373	158 8%
OneCare Connect	1,474	198	1,276	644 4%
OneCare	(53)	12	(65)	(541 7%)
PACE	347	370	(23)	(6 2%)
505 Bldg	-	-	-	0 0%
Investment Income & Other	(372)	1,250	(1,622)	(129 8%)
Total	$ 11,781	$ 5,842	$ 5,939	101 7%

MLR	Actual	Budget	% Point Var
Medi-Cal	93 6%	94 1%	0 4
OneCare Connect	89 0%	92 9%	3 9
OneCare	93 4%	90 6%	(2 8)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,440	$ 10,251	$ 811	7 9%
OneCare Connect	1,366	1,584	218	13 8%
OneCare	174	135	(39)	(29 3%)
PACE	162	191	29	15 1%
Total	$ 11,142	$ 12,161	$ 1,019	8 4%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,079	1,161	82
OneCare Connect	197	210	13
OneCare	10	9	(1)
PACE	95	116	21
Total	1,381	1,496	115

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	736	684	52
OneCare Connect	74	66	7
OneCare	164	148	16
PACE	4	4	0
Total	978	902	76

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,242,801	6,219,327	23,474	0 4%
OneCare Connect	117,270	112,326	4,944	4 4%
OneCare	12,763	11,024	1,739	15 8%
PACE	3,097	3,365	(268)	(8 0%)
Total	6,375,931	6,346,042	29,889	0 5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 16,079	$ (15,226)	$ 31,305	205 6%
OneCare Connect	89	(6,761)	6,850	101 3%
OneCare	272	246	26	10 6%
PACE	4,182	1,569	2,613	166 5%
505 Bldg	-	-	-	0 0%
Investment Income & Other	5,115	10,000	(4,885)	(48 9%)
Total	$ 25,737	$ (10,172)	$ 35,909	353 0%

MLR	Actual	Budget	% Point Var
Medi-Cal	96 1%	96 9%	0 8
OneCare Connect	94 6%	97 0%	2 4
OneCare	90 4%	89 9%	(0 5)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 74,577	$ 85,187	$ 10,611	12 5%
OneCare Connect	12,058	12,837	778	6 1%
OneCare	1,251	1,091	(159)	(14 6%)
PACE	1,240	1,419	180	12 6%
Total	$ 89,125	$ 100,535	$ 11,409	11 3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,655	9,286	632
OneCare Connect	1,526	1,678	152
OneCare	80	74	(6)
PACE	731	930	199
Total	10,993	11,969	976

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	721	670	52
OneCare Connect	77	67	10
OneCare	159	148	10
PACE	4	4	1
Total	961	888	73

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended February 28, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	810,105		809,437		668	
REVENUE						
Medi-Cal	$ 293,886,536	$ 370.37	$ 239,369,478	$ 301.60	$ 54,517,058	$ 68.77
OneCare Connect	25,864,516	1,775 31	25,270,908	1,811.79	593,608	(36.48)
OneCare	1,829,169	1,111 96	1,560,731	1,132.61	268,438	(20.65)
PACE	3,358,220	8,588.80	3,585,324	8,075.05	(227,104)	513.75
Total Operating Revenue	324,938,441	401.11	269,786,441	333.30	55,152,000	67.81
MEDICAL EXPENSES						
Medi-Cal	275,134,509	346.74	225,106,052	283.63	(50,028,457)	(63.11)
OneCare Connect	23,024,410	1,580 37	23,488,341	1,683.99	463,931	103.62
OneCare	1,708,627	1,038.68	1,413,934	1,026.08	(294,693)	(12.60)
PACE	2,849,009	7,286.47	3,024,275	6,811.43	175,266	(475.04)
Total Medical Expenses	302,716,555	373.68	253,032,602	312.60	(49,683,953)	(61.08)
GROSS MARGIN	22,221,886	27.43	16,753,839	20.70	5,468,047	6.73
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,331,166	9.05	7,582,499	9.37	251,333	0.32
Professional fees	296,768	0.37	376,770	0.47	80,002	0.10
Purchased services	958,491	1.18	1,086,326	1.34	127,835	0.16
Printing & Postage	215,332	0.27	575,359	0.71	360,027	0.44
Depreciation & Amortization	263,767	0.33	460,570	0.57	196,803	0.24
Other expenses	1,748,936	2.16	1,699,369	2.10	(49,567)	(0.06)
Indirect cost allocation & Occupancy expense	327,310	0.40	379,683	0.47	52,373	0.07
Total Administrative Expenses	11,141,769	13.75	12,160,576	15.02	1,018,807	1.27
INCOME (LOSS) FROM OPERATIONS	11,080,117	13.68	4,593,263	5.67	6,486,854	8.01
INVESTMENT INCOME						
Interest income	760,881	0.94	1,250,000	1.54	(489,119)	(0.60)
Realized gain/(loss) on investments	227,477	0.28	-	-	227,477	0.28
Unrealized gain/(loss) on investments	(1,360,646)	(1.68)	-	-	(1,360,646)	(1.68)
Total Investment Income	(372,287)	(0.46)	1,250,000	1.54	(1,622,287)	(2.00)
TOTAL MCO TAX	1,072,204	1.32	0	-	1,072,204	1.32
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**11,780,049**	**14.54**	**5,843,263**	**7.22**	**5,936,786**	**7.32**
MEDICAL LOSS RATIO	**93.2%**		**93.8%**		**0.6%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.5%**		**1 1%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,375,931		6,346,042		29,889	
REVENUE						
Medi-Cal	$ 2,341,168,895	$ 375 02	$ 2,223,924,196	$ 357 58	$ 117,244,699	$ 17 44
OneCare Connect	225,809,302	1,925 55	205,515,397	1,829 63	20,293,905	95 92
OneCare	15,920,228	1,247 37	13,237,507	1,200 79	2,682,721	46 58
PACE	26,025,856	8,403 57	27,298,158	8,112 38	(1,272,302)	291 19
Total Operating Revenue	2,608,924,280	409 18	2,469,975,258	389 22	138,949,022	19 96
MEDICAL EXPENSES						
Medi-Cal	2,250,023,856	360 42	2,153,962,941	346 33	(96,060,915)	(14 09)
OneCare Connect	213,661,531	1,821 96	199,439,234	1,775 54	(14,222,297)	(46 42)
OneCare	14,397,856	1,128 09	11,900,085	1,079 47	(2,497,771)	(48 62)
PACE	20,603,892	6,652 86	24,309,862	7,224 33	3,705,970	571 47
Total Medical Expenses	2,498,687,136	391 89	2,389,612,122	376 55	(109,075,014)	(15 34)
GROSS MARGIN	110,237,145	17 29	80,363,136	12 67	29,874,009	4 62
ADMINISTRATIVE EXPENSES						
Salaries and benefits	61,343,785	9 62	62,786,826	9 89	1,443,041	0 27
Professional fees	1,316,812	0 21	2,977,020	0 47	1,660,208	0 26
Purchased services	7,271,121	1 14	9,868,359	1 56	2,597,238	0 42
Printing & Postage	2,632,413	0 41	4,580,372	0 72	1,947,959	0 31
Depreciation & Amortization	2,319,868	0 36	3,684,560	0 58	1,364,692	0 22
Other expenses	11,415,039	1 79	13,571,815	2 14	2,156,776	0 35
Indirect cost allocation & Occupancy expense	2,826,270	0 44	3,065,756	0 48	239,486	0 04
Total Administrative Expenses	89,125,309	13 98	100,534,708	15 84	11,409,399	1 86
INCOME (LOSS) FROM OPERATIONS	21,111,836	3 31	(20,171,572)	(3 18)	41,283,408	6 49
INVESTMENT INCOME						
Interest income	8,032,709	1 26	10,000,000	1 58	(1,967,291)	(0 32)
Realized gain/(loss) on investments	4,269,548	0 67	-	-	4,269,548	0 67
Unrealized gain/(loss) on investments	(7,187,385)	(1 13)	-	-	(7,187,385)	(1 13)
Total Investment Income	5,114,871	0 80	10,000,000	1 58	(4,885,129)	(0 78)
TOTAL MCO TAX	(503,796)	(0 08)	-	-	(503,796)	(0 08)
TOTAL GRANT INCOME	14,050	-	-	-	14,050	-
OTHER INCOME	330	-	-	-	330	-
CHANGE IN NET ASSETS	**25,737,291**	**4.04**	**(10,171,572)**	**(1.60)**	**35,908,863**	**5.64**
MEDICAL LOSS RATIO	**95.8%**		**96.7%**		**1.0%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.1%**		**0.7%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended February 28, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	509,288	272,590	11,622	793,500	14,569	1,645	391	810,105
REVENUES								
Capitation Revenue	149,920,169	$ 120,003,535	$ 23,962,832	$ 293,886,536	$ 25,864,516	$ 1,829,169	$ 3,358,220	$ 324,938,441
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	149,920,169	120,003,535	23,962,832	293,886,536	25,864,516	1,829,169	3,358,220	324,938,441
MEDICAL EXPENSES								
Provider Capitation	47,502,832	47,816,733	18,583,804	113,903,370	9,786,251	501,932		124,191,553
Facilities	24,344,570	24,279,488	(5,620,513)	43,003,545	6,345,891	590,616	1,034,856	50,974,909
Professional Claims	18,958,868	9,291,637	1,238,973	29,489,478	886,047	30,549	599,905	31,005,979
Prescription Drugs	19,164,595	24,751,912	5,730,698	49,647,205	3,424,521	510,434	268,732	53,850,892
MLTSS	28,996,270	2,681,672	1,879,163	33,557,104	1,220,072	43,659	86,036	34,906,871
Medical Management	2,055,256	1,244,310	258,634	3,558,201	1,002,397	31,437	797,219	5,389,253
Quality Incentives	857,939	533,928	35,407	1,427,274	212,640		4,888	1,644,801
Reinsurance & Other	346,145	191,001	11,188	548,334	146,590		57,373	752,297
Total Medical Expenses	142,226,474	110,790,681	22,117,353	275,134,509	23,024,410	1,708,627	2,849,009	302,716,555
Medical Loss Ratio	94 9%	92 3%	92 3%	93 6%	89 0%	93 4%	84 8%	93 2%
GROSS MARGIN	**7,693,695**	**9,212,854**	**1,845,478**	**18,752,027**	**2,840,106**	**120,541**	**509,211**	**22,221,886**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,476,912	661,627	77,230	115,397	7,331,166
Professional fees				222,215	35,468	38,961	123	296,768
Purchased services				909,937	29,930	7,936	10,687	958,491
Printing & Postage				157,767	38,139	7,680	11,747	215,332
Depreciation & Amortization				261,747			2,020	263,767
Other expenses				1,729,300	1,889		17,748	1,748,936
Indirect cost allocation & Occupancy				(318,255)	599,155	42,173	4,237	327,310
Total Administrative Expenses				9,439,622	1,366,208	173,980	161,959	11,141,769
Admin Loss Ratio				3 2%	5 3%	9 5%	4 8%	3 4%
INCOME (LOSS) FROM OPERATIONS				9,312,405	1,473,899	(53,439)	347,253	11,080,117
INVESTMENT INCOME								(372,287)
TOTAL MCO TAX				1,072,204				1,072,204
OTHER INCOME				15				15
CHANGE IN NET ASSETS				**$ 10,384,624**	**$ 1,473,899**	**$ (53,439)**	**$ 347,253**	**$ 11,780,049**
BUDGETED CHANGE IN NET ASSETS				4,012,354	198,408	12,251	370,250	5,843,263
VARIANCE TO BUDGET - FAV (UNFAV)				$ 6,372,270	$ 1,275,491	$ (65,690)	$ (22,997)	$ 5,936,786

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ended February 28, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,072,342	2,078,356	92,103	6,242,801	117,270	12,763	3,097	6,375,931
REVENUES								
Capitation Revenue	1,216,175,279	$ 939,068,249	$ 185,925,366	$ 2,341,168,895	$ 225,809,302	$ 15,920,228	$ 26,025,856	$ 2,608,924,280
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,216,175,279	939,068,249	185,925,366	2,341,168,895	225,809,302	15,920,228	26,025,856	2,608,924,280
MEDICAL EXPENSES								
Provider Capitation	299,580,594	354,391,582	97,877,745	751,849,921	96,209,345	4,382,244		852,441,510
Facilities	189,713,407	200,412,111	11,987,498	402,113,016	39,729,154	4,201,194	5,259,722	451,303,086
Professional Claims	157,310,804	72,618,657	8,181,237	238,110,699	7,844,189	591,269	4,813,280	251,359,437
Prescription Drugs	158,639,729	199,470,664	41,916,227	400,026,621	47,131,131	4,691,004	2,268,590	454,117,345
MLTSS	267,190,322	22,560,096	15,126,407	304,876,825	11,275,546	241,570	488,093	316,882,035
Medical Management	18,563,278	10,989,997	2,328,972	31,882,248	8,643,259	290,575	6,803,068	47,619,149
Quality Incentives	8,930,921	4,116,314	491,258	13,538,493	1,732,125		123,072	15,393,690
Reinsurance & Other	59,749,229	47,779,941	96,866	107,626,035	1,096,782		848,068	109,570,884
Total Medical Expenses	1,159,678,286	912,339,361	178,006,210	2,250,023,856	213,661,531	14,397,856	20,603,892	2,498,687,136
Medical Loss Ratio	95 4%	97 2%	95 7%	96 1%	94 6%	90 4%	79 2%	95 8%
GROSS MARGIN	**56,496,994**	**26,728,888**	**7,919,157**	**91,145,038**	**12,147,771**	**1,522,372**	**5,421,964**	**110,237,145**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				54,181,804	5,573,914	660,206	927,862	61,343,785
Professional fees				1,025,782	149,030	140,973	1,027	1,316,812
Purchased services				6,430,932	646,154	65,198	128,837	7,271,121
Printing & Postage				1,851,012	637,271	46,649	97,480	2,632,413
Depreciation & Amortization				2,303,648			16,220	2,319,868
Other expenses				11,118,846	258,862	205	37,126	11,415,039
Indirect cost allocation & Occupancy				(2,335,512)	4,793,237	337,386	31,160	2,826,270
Total Administrative Expenses				74,576,513	12,058,468	1,250,617	1,239,711	89,125,309
Admin Loss Ratio				3 2%	5 3%	7 9%	4 8%	3 4%
INCOME (LOSS) FROM OPERATIONS				16,568,525	89,303	271,754	4,182,253	21,111,836
INVESTMENT INCOME								5,114,871
TOTAL MCO TAX				(503,796)				(503,796)
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				330				330
CHANGE IN NET ASSETS				**$ 16,079,109**	**$ 89,303**	**$ 271,754**	**$ 4,182,253**	**$ 25,737,291**
BUDGETED CHANGE IN NET ASSETS				(15,226,078)	(6,760,644)	246,070	1,569,080	(10,171,572)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,305,187	$ 6,849,947	$ 25,684	$ 2,613,173	$ 35,908,863

February 28, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $11.8 million, $5.9 million favorable to budget
- Operating surplus is $11.1 million, with a surplus in non-operating income of $0.7 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $25.7 million, $35.9 million favorable to budget
- Operating surplus is $21.1 million, with a surplus in non-operating income of $4.6 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
9.3	4.0	5.3	Medi-Cal	16.6	(15.2)	31.8
1.5	0.2	1.3	OCC	0.1	(6.8)	6.8
(0.1)	0.0	(0.1)	OneCare	0.3	0.2	0.0
0.3	0.4	(0.0)	PACE	4.2	1.6	2.6
11.1	**4.6**	**6.5**	**Operating**	**21.1**	**(20.2)**	**41.3**
0.7	1.3	(0.6)	Inv./Rental Inc, MCO tax	4.6	10.0	(5.4)
0.7	**1.3**	**(0.6)**	**Non-Operating**	**4.6**	**10.0**	**(5.4)**
11.8	**5.8**	**5.9**	**TOTAL**	**25.7**	**(10.2)**	**35.9**

CalOptima - Consolidated
Enrollment Summary
For the Eight Months Ended February 28, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
107,949	111,051	(3,102)	(2.8%)	SPD	915,581	887,317	28,264	3.2%
517	468	49	10.5%	BCCTP	4,117	3,838	279	7.3%
294,933	317,408	(22,475)	(7.1%)	TANF Child	2,335,194	2,472,905	(137,711)	(5.6%)
102,882	95,389	7,493	7.9%	TANF Adult	791,488	743,639	47,849	6.4%
3,007	3,519	(512)	(14.5%)	LTC	25,962	28,096	(2,134)	(7.6%)
272,590	253,901	18,689	7.4%	MCE	2,078,356	1,988,079	90,277	4.5%
11,622	11,931	(309)	(2.6%)	WCM	92,103	95,453	(3,350)	(3.5%)
793,500	**793,667**	**(167)**	**(0.0%)**	**Medi-Cal Total**	**6,242,801**	**6,219,327**	**23,474**	**0.4%**
14,569	**13,948**	**621**	**4.5%**	**OneCare Connect**	**117,270**	**112,326**	**4,944**	**4.4%**
1,645	**1,378**	**267**	**19.4%**	**OneCare**	**12,763**	**11,024**	**1,739**	**15.8%**
391	**444**	**(53)**	**(11.9%)**	**PACE**	**3,097**	**3,365**	**(268)**	**(8.0%)**
810,105	**809,437**	**668**	**0.1%**	**CalOptima Total**	**6,375,931**	**6,346,042**	**29,889**	**0.5%**
				Enrollment (by Network)				
182,954	176,081	6,873	3.9%	HMO	1,422,519	1,385,018	37,501	2.7%
222,679	229,056	(6,377)	(2.8%)	PHC	1,754,032	1,794,186	(40,154)	(2.2%)
193,460	197,651	(4,191)	(2.1%)	Shared Risk Group	1,506,440	1,529,951	(23,511)	(1.5%)
194,407	190,879	3,528	1.8%	Fee for Service	1,559,810	1,510,172	49,638	3.3%
793,500	**793,667**	**(167)**	**(0.0%)**	**Medi-Cal Total**	**6,242,801**	**6,219,327**	**23,474**	**0.4%**
14,569	**13,948**	**621**	**4.5%**	**OneCare Connect**	**117,270**	**112,326**	**4,944**	**4.4%**
1,645	**1,378**	**267**	**19.4%**	**OneCare**	**12,763**	**11,024**	**1,739**	**15.8%**
391	**444**	**(53)**	**(11.9%)**	**PACE**	**3,097**	**3,365**	**(268)**	**(8.0%)**
810,105	**809,437**	**668**	**0.1%**	**CalOptima Total**	**6,375,931**	**6,346,042**	**29,889**	**0.5%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588	10,639	10,658	10,725	11,756	9,640					85,125	82,816	2,309
BCCTP	1	1	1	1	1	1	1	1					8	8	0
TANF Child	54,644	55,088	55,115	55,276	55,934	56,264	56,566	56,582					445,469	464,970	(19,501)
TANF Adult	29,033	29,687	30,001	30,679	30,990	31,336	31,677	31,995					245,398	234,659	10,739
LTC	(1)	402	197	215	239	238	(1,283)						7	16	(9)
MCE	74,441	75,955	76,054	78,435	79,490	80,792	82,386	82,587					630,140	586,189	43,951
WCM	1,721	1,726	2,086	2,507	2,007	2,067	2,109	2,149					16,372	16,360	12
Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**	**181,423**	**183,212**	**182,954**					**1,422,519**	**1,385,018**	**37,501**
PHCs															
SPD	7,145	7,205	6,855	6,760	7,010	7,042	7,103	6,774					55,894	56,177	(283)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336	152,122	152,428	152,751	152,998					1,210,327	1,272,804	(62,477)
TANF Adult	11,688	12,097	12,071	12,492	12,728	12,694	12,930	13,071					99,771	93,111	6,660
LTC		158	81	65	76	80	(456)						4	8	(4)
MCE	39,815	40,711	39,935	41,371	41,820	42,350	42,781	42,628					331,411	314,620	16,791
WCM	5 625	5 716	7 990	8 497	6 957	7 099	7 533	7 208					56 625	57 466	(841)
Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**	**221,693**	**222,642**	**222,679**					**1,754,032**	**1,794,186**	**(40,154)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117	10,120	10,261	10,927	9,519					81,588	80,704	884
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133	58,881	58,952	59,011	58,901					468,123	517,938	(49,815)
TANF Adult	28,914	29,648	29,235	30,414	30,910	31,050	31,495	31,655					243,321	237,330	5,991
LTC	1	365	178	209	217	219	(1,185)	(1)					3	16	(13)
MCE	82,747	84,907	83,063	87,432	88,969	90,268	92,357	92,006					701,749	680,422	21,327
WCM	924	1,000	1,954	2,189	1,382	1,408	1,419	1,380					11,656	13,541	(1,885)
Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**	**192,158**	**194,024**	**193,460**					**1,506,440**	**1,529,951**	**(23,511)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815	76,628	77,616	85,109	73,178					614,428	588,449	25,979
BCCTP	12	17	18	18	14	14	16	15					124	136	(12)
TANF Child	1	1	1	1	1	1	1	1					8	19	(11)
TANF Adult	909	1,266	994	1,107	1,015	1,030	1,064	1,119					8,504	7,968	536
LTC	3,079	4,461	3,855	3,838	3,818	3,817	(2,123)	2,706					23,451	25,312	(1,861)
MCE	1,658	1,859	1,948	2,077	2,138	2,334	2,430	2,390					16,834	12,395	4,439
WCM	13	17	16	17	15	14	17	15					124	104	20
Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**	**84,826**	**86,514**	**79,424**					**663,473**	**634,383**	**29,090**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977	9,304	9,774	10,737	8,838					78,546	79,171	(625)
BCCTP	497	492	499	506	485	490	515	501					3,985	3,694	291
TANF Child	25,494	27,007	28,092	26,150	26,005	25,664	26,404	26,451					211,267	217,174	(5,907)
TANF Adult	23,028	24,014	24,847	24,196	24,229	24,315	24,823	25,042					194,494	170,571	23,923
LTC	351	788	580	573	560	580	(1,237)	302					2,497	2,744	(247)
MCE	45,498	47,292	52,445	48,625	49,046	49,527	52,810	52,979					398,222	394,453	3,769
WCM	791	806	974	1,076	896	899	1,014	870					7,326	7,982	(656)
Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**	**111,249**	**115,066**	**114,983**					**896,337**	**875,789**	**20,548**
SPD	112,390	113,120	113,044	114,308	113,720	115,418	125,632	107,949					915,581	887,317	28,264
BCCTP	510	510	518	525	500	505	532	517					4,117	3,838	279
TANF Child	288,238	291,791	289,351	289,896	292,943	293,309	294,733	294,933					2,335,194	2,472,905	(137,711)
TANF Adult	93,572	96,712	97,148	98,888	99,872	100,425	101,989	102,882					791,488	743,639	47,849
LTC	3,430	6,174	4,891	4,900	4,910	4,934	(6,284)	3,007					25,962	28,096	(2,134)
MCE	244,159	250,724	253,445	257,940	261,463	265,271	272,764	272,590					2,078,356	1,988,079	90,277
WCM	9 074	9 265	13 020	14 286	11 257	11 487	12 092	11 622					92 103	95 453	(3 350)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**	**791,349**	**801,458**	**793,500**					**6,242,801**	**6,219,327**	**23,474**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**	**14,938**	**14,921**	**14,569**					**117,270**	**112,326**	**4,944**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**	**1,609**	**1,615**	**1,645**					**12,763**	**11,024**	**1,739**
PACE	**382**	**381**	**380**	**387**	**393**	**394**	**389**	**391**					**3,097**	**3,365**	**(268)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**	**808,290**	**818,383**	**810,105**					**6,375,931**	**6,346,042**	**29,889**

ENROLLMENT:

Overall, February enrollment was 810,105

- Favorable to budget 668 or 0.1%
- Decreased 8,278 or 1.0% from prior month (PM) (January 2021)
- Increased 88,877 or 12.3% from prior year (PY) (February 2020)

Medi-Cal enrollment was 793,500

- Unfavorable to budget 167 or 0.0% due to prior period retroactivity of approximately 9,600 members
  - Temporary Assistance for Needy Families (TANF) unfavorable 14,982
  - Seniors and Persons with Disabilities (SPD) unfavorable 3,102
  - Long-Term Care (LTC) unfavorable 512
  - Whole Child Model (WCM) unfavorable 309
  - Medi-Cal Expansion (MCE) favorable 18,689
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 49
- Decreased 7,958 from PM

OneCare Connect enrollment was 14,569

- Favorable to budget 621 or 4.5%
- Decreased 352 from PM

OneCare enrollment was 1,645

- Favorable to budget 267 or 19.4%
- Increased 30 from PM

PACE enrollment was 391

- Unfavorable to budget 53 or 11.9%
- Increased 2 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
793,500	**793,667**	**(167)**	**(0.0%)**	**Member Months**	**6,242,801**	**6,219,327**	**23,474**	**0.4%**
				Revenues				
293,886,536	239,369,478	54,517,058	22 8%	Capitation Revenue	2,341,168,895	2,223,924,196	117,244,699	5 3%
-	-	-	0 0%	Other Income	-	-	-	0 0%
293,886,536	**239,369,478**	**54,517,058**	**22.8%**	**Total Operating Revenue**	**2,341,168,895**	**2,223,924,196**	**117,244,699**	**5.3%**
				Medical Expenses				
115,330,643	96,134,954	(19,195,689)	(20 0%)	Provider Capitation	765,388,414	781,627,103	16,238,689	2 1%
43,003,545	55,407,308	12,403,763	22 4%	Facilities Claims	402,113,016	464,688,977	62,575,961	13 5%
29,489,478	31,249,215	1,759,737	5 6%	Professional Claims	238,110,699	262,636,965	24,526,266	9 3%
49,647,205	-	(49,647,205)	0 0%	Prescription Drugs	400,026,621	280,984,863	(119,041,758)	(42 4%)
33,557,104	37,203,538	3,646,434	9 8%	MLTSS	304,876,825	320,441,020	15,564,195	4 9%
3,558,201	4,507,031	948,830	21 1%	Medical Management	31,882,248	38,751,959	6,869,711	17 7%
548,334	604,006	55,672	9 2%	Reinsurance & Other	107,626,035	4,832,054	(102,793,981)	(2127 3%)
275,134,509	**225,106,052**	**(50,028,457)**	**(22.2%)**	**Total Medical Expenses**	**2,250,023,856**	**2,153,962,941**	**(96,060,915)**	**(4.5%)**
18,752,027	**14,263,426**	**4,488,601**	**31.5%**	**Gross Margin**	**91,145,038**	**69,961,255**	**21,183,783**	**30.3%**
				Administrative Expenses				
6,476,912	6,630,331	153,419	2 3%	Salaries, Wages & Employee Benefits	54,181,804	54,986,122	804,318	1 5%
222,215	320,521	98,306	30 7%	Professional Fees	1,025,782	2,527,028	1,501,246	59 4%
909,937	933,513	23,576	2 5%	Purchased Services	6,430,932	8,733,355	2,302,423	26 4%
157,767	443,433	285,666	64 4%	Printing and Postage	1,851,012	3,547,464	1,696,452	47 8%
261,747	458,500	196,753	42 9%	Depreciation & Amortization	2,303,648	3,668,000	1,364,352	37 2%
1,729,300	1,678,434	(50,866)	(3 0%)	Other Operating Expenses	11,118,846	13,405,173	2,286,327	17 1%
(318,255)	(213,660)	104,595	49 0%	Indirect Cost Allocation, Occupancy Expense	(2,335,512)	(1,679,809)	655,703	39 0%
9,439,622	**10,251,072**	**811,450**	**7.9%**	**Total Administrative Expenses**	**74,576,513**	**85,187,333**	**10,610,820**	**12.5%**
				Operating Tax				
13,540,954	15,362,776	(1,821,822)	(11 9%)	Tax Revenue	99,246,204	120,422,848	(21,176,644)	(17 6%)
12,468,750	15,362,776	2,894,026	18 8%	Premium Tax Expense	99,750,000	120,422,848	20,672,848	17 2%
-	-	-	0 0%	Sales Tax Expense	-	-	-	0 0%
1,072,204	0	1,072,204	**0.0%**	**Total Net Operating Tax**	(503,796)	-	(503,796)	**0.0%**
				Grant Income				
9,051	-	9,051	0 0%	Grant Revenue	264,155	-	264,155	0 0%
-	-	-	0 0%	Grant expense - Service Partner	201,238	-	(201,238)	0 0%
9,051	-	(9,051)	0 0%	Grant expense - Administrative	48,867	-	(48,867)	0 0%
-	-	-	**0.0%**	**Total Grant Income**	14,050	-	14,050	**0.0%**
15	**-**	**15**	**0.0%**	**Other income**	**330**	**-**	**330**	**0.0%**
10,384,624	**4,012,354**	**6,372,270**	**158.8%**	**Change in Net Assets**	**16,079,109**	**(15,226,078)**	**31,305,187**	**205.6%**
93.6%	***94.0%***	***0.4%***	***0.4%***	***Medical Loss Ratio***	***96.1%***	***96.9%***	***0.7%***	***0.8%***
3.2%	***4.3%***	***1.1%***	***25.0%***	***Admin Loss Ratio***	***3.2%***	***3.8%***	***0.6%***	***16.8%***

MEDI-CAL INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $293.9 million are favorable to budget $54.5 million driven by:

- Unfavorable volume related variance of $0.1 million
- Favorable price related variance of $54.6 million
  - $52.0 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
  - $2.9 million of Fiscal Year (FY) 2021 revenue from Coordinated Care Initiative (CCI)
  - $2.4 million of FY 2021 revenue from Behavioral Health Integration (BHI)
  - $1.5 million of revenue from WCM due to retroactive enrollment
  - Offset by $6.8 million of Bridge Period Gross Medical Expenditures (GME) risk corridor
  - $2.2 million of PY Proposition 56 risk corridor reserve

MEDICAL EXPENSES of $275.1 million are unfavorable to budget $50.0 million driven by:

- Favorable volume related variance of $47.4 thousand
- Unfavorable price related variance of $50.1 million
  - Prescription Drugs expense unfavorable variance of $49.6 million due to DHCS postponing pharmacy benefit transition to FFS
  - Provider Capitation expense unfavorable variance of $19.2 million due to WCM and additional 5% short-term supplemental payments to the networks
  - Offset by Facilities Claims expense favorable variance of $12.4 million due to release of prior year Neonatal Intensive Care Unit (NICU) accrual and decreased utilization during COVID-19 pandemic
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $3.6 million due to decreased utilization and Incurred But Not Reported (IBNR)

ADMINISTRATIVE EXPENSES of $9.4 million are favorable to budget $0.8 million driven by:

- Other Non-Salary expense favorable to budget $0.7 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $10.4 million for the month, favorable to budget $6.4 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eight Months Ending February 28, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,569	**13,948**	**621**	**4.5%**	**Member Months**	**117,270**	**112,326**	**4,944**	**4.4%**
				Revenues				
2,617,181	2,692,287	(75,106)	(2.8%)	Medi-Cal Capitation Revenue	23,469,314	21,684,388	1,784,926	8.2%
17,759,019	17,522,582	236,437	1.3%	Medicare Capitation Revenue Part C	157,773,939	142,413,896	15,360,043	10.8%
5,488,317	5,056,039	432,278	8.5%	Medicare Capitation Revenue Part D	44,566,050	41,417,113	3,148,937	7.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
25,864,516	**25,270,908**	**593,608**	**2.3%**	**Total Operating Revenue**	**225,809,302**	**205,515,397**	**20,293,905**	**9.9%**
				Medical Expenses				
9,998,891	10,717,870	718,979	6.7%	Provider Capitation	97,941,470	89,874,174	(8,067,296)	(9.0%)
6,345,891	3,713,084	(2,632,807)	(70.9%)	Facilities Claims	39,729,154	31,855,898	(7,873,256)	(24.7%)
886,047	878,542	(7,505)	(0.9%)	Ancillary	7,844,189	7,490,955	(353,234)	(4.7%)
1,220,072	1,385,754	165,682	12.0%	MLTSS	11,275,546	12,184,345	908,799	7.5%
3,424,521	5,451,276	2,026,755	37.2%	Prescription Drugs	47,131,131	46,854,257	(276,874)	(0.6%)
1,002,397	1,136,846	134,449	11.8%	Medical Management	8,643,259	9,446,717	803,458	8.5%
146,590	204,969	58,379	28.5%	Other Medical Expenses	1,096,782	1,732,888	636,106	36.7%
23,024,410	**23,488,341**	**463,931**	**2.0%**	**Total Medical Expenses**	**213,661,531**	**199,439,234**	**(14,222,297)**	**(7.1%)**
2,840,106	**1,782,567**	**1,057,539**	**59.3%**	**Gross Margin**	**12,147,771**	**6,076,163**	**6,071,608**	**99.9%**
				Administrative Expenses				
661,627	764,794	103,167	13.5%	Salaries, Wages & Employee Benefits	5,573,914	6,278,905	704,991	11.2%
35,468	40,083	4,615	11.5%	Professional Fees	149,030	320,664	171,634	53.5%
29,930	103,412	73,482	71.1%	Purchased Services	646,154	827,296	181,142	21.9%
38,139	106,517	68,378	64.2%	Printing and Postage	637,271	852,136	214,865	25.2%
1,889	15,861	13,972	88.1%	Other Operating Expenses	258,862	129,870	(128,992)	(99.3%)
599,155	553,492	(45,663)	(8.2%)	Indirect Cost Allocation	4,793,237	4,427,936	(365,301)	(8.2%)
1,366,208	**1,584,159**	**217,951**	**13.8%**	**Total Administrative Expenses**	**12,058,468**	**12,836,807**	**778,339**	**6.1%**
1,473,899	**198,408**	**1,275,491**	**642.9%**	**Change in Net Assets**	**89,303**	**(6,760,644)**	**6,849,947**	**101.3%**
89.0%	***92.9%***	***3.9%***	***4.2%***	***Medical Loss Ratio***	***94.6%***	***97.0%***	***2.4%***	***2.5%***
5.3%	***6.3%***	***1.0%***	***15.7%***	***Admin Loss Ratio***	***5.3%***	***6.2%***	***0.9%***	***14.5%***

ONECARE CONNECT INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $25.9 million are favorable to budget $0.6 million driven by:

- Favorable volume related variance of $1.1 million
- Unfavorable price related variance of $0.5 million

MEDICAL EXPENSES of $23.0 million are favorable to budget $0.5 million driven by:

- Unfavorable volume related variance of $1.0 million
- Favorable price related variance of $1.5 million
  - Prescription Drugs expense favorable variance of $2.3 million due to 2019 and 2020 pharmacy rebates received in February 2021
  - Provider Capitation expense favorable variance of $1.2 million
  - MLTSS expense favorable variance of $0.2 million
  - Offset by Facilities Claims expense unfavorable variance of $2.5 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is $1.5 million, favorable to budget $1.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,645	**1,378**	**267**	**19.4%**	**Member Months**	**12,763**	**11,024**	**1,739**	**15.8%**
				Revenues				
1,329,213	1,074,625	254,588	23 7%	Medicare Part C revenue	11,015,427	9,042,302	1,973,125	21 8%
499,955	486,106	13,849	2 8%	Medicare Part D revenue	4,904,801	4,195,205	709,596	16 9%
1,829,169	**1,560,731**	**268,438**	**17.2%**	**Total Operating Revenue**	**15,920,228**	**13,237,507**	**2,682,721**	**20.3%**
				Medical Expenses				
501,932	424,759	(77,173)	(18 2%)	Provider Capitation	4,382,244	3,518,643	(863,601)	(24 5%)
590,616	426,474	(164,142)	(38 5%)	Inpatient	4,201,194	3,601,803	(599,391)	(16 6%)
30,549	40,994	10,445	25 5%	Ancillary	591,269	342,809	(248,460)	(72 5%)
43,659	23,389	(20,270)	(86 7%)	Skilled Nursing Facilities	241,570	202,982	(38,588)	(19 0%)
510,434	456,121	(54,313)	(11 9%)	Prescription Drugs	4,691,004	3,887,893	(803,111)	(20 7%)
31,437	42,046	10,609	25 2%	Medical Management	290,575	345,652	55,077	15 9%
-	151	151	100 0%	Other Medical Expenses	-	303	303	100 0%
1,708,627	**1,413,934**	**(294,693)**	**(20.8%)**	**Total Medical Expenses**	**14,397,856**	**11,900,085**	**(2,497,771)**	**(21.0%)**
120,541	**146,797**	**(26,256)**	**(17.9%)**	**Gross Margin**	**1,522,372**	**1,337,422**	**184,950**	**13.8%**
				Administrative Expenses				
77,230	64,990	(12,240)	(18 8%)	Salaries, wages & employee benefits	660,206	534,904	(125,302)	(23 4%)
38,961	16,000	(22,961)	(143 5%)	Professional fees	140,973	128,000	(12,973)	(10 1%)
7,936	9,750	1,814	18 6%	Purchased services	65,198	78,000	12,802	16 4%
7,680	8,084	404	5 0%	Printing and postage	46,649	64,672	18,023	27 9%
-	537	537	100 0%	Other operating expenses	205	4,296	4,091	95 2%
42,173	35,185	(6,988)	(19 9%)	Indirect cost allocation, occupancy expens	337,386	281,480	(55,906)	(19 9%)
173,980	**134,546**	**(39,434)**	**(29.3%)**	**Total Administrative Expenses**	**1,250,617**	**1,091,352**	**(159,265)**	**(14.6%)**
(53,439)	**12,251**	**(65,690)**	**(536.2%)**	**Change in Net Assets**	**271,754**	**246,070**	**25,684**	**10.4%**
93.4%	***90.6%***	***(2.8%)***	***(3.1%)***	***Medical Loss Ratio***	***90.4%***	***89.9%***	***(0.5%)***	***(0.6%)***
9.5%	***8.6%***	***(0.9%)***	***(10.3%)***	***Admin Loss Ratio***	***7.9%***	***8.2%***	***0.4%***	***4.7%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
391	**444**	**(53)**	**(11.9%)**	**Member Months**	**3,097**	**3,365**	**(268)**	**-8.0%**
				Revenues				
2,471,316	2,794,654	(323,338)	(11 6%)	Medi-Cal Capitation Revenue	19,500,003	21,185,391	(1,685,388)	(8 0%)
738,361	634,260	104,101	16 4%	Medicare Part C Revenue	5,169,595	4,918,682	250,913	5 1%
148,544	156,410	(7,866)	(5 0%)	Medicare Part D Revenue	1,356,258	1,194,085	162,173	13 6%
3,358,220	**3,585,324**	**(227,104)**	**(6.3%)**	**Total Operating Revenue**	**26,025,856**	**27,298,158**	**(1,272,302)**	**(4.7%)**
				Medical Expenses				
797,219	958,689	161,470	16 8%	Medical Management	6,803,068	7,670,037	866,969	11 3%
1,034,856	800,246	(234,610)	(29 3%)	Facilities Claims	5,259,722	6,404,387	1,144,665	17 9%
599,905	659,940	60,035	9 1%	Professional Claims	4,813,280	5,347,950	534,670	10 0%
57,373	250,990	193,617	77 1%	Patient Transportation	848,068	2,029,716	1,181,648	58 2%
268,732	269,854	1,122	0 4%	Prescription Drugs	2,268,590	2,197,719	(70,871)	(3 2%)
86,036	66,516	(19,520)	(29 3%)	MLTSS	488,093	511,823	23,730	4 6%
4,888	18,040	13,153	72 9%	Other Expenses	123,072	148,230	25,159	17 0%
2,849,009	**3,024,275**	**175,266**	**5.8%**	**Total Medical Expenses**	**20,603,892**	**24,309,862**	**3,705,970**	**15.2%**
509,211	**561,049**	**(51,838)**	**-9.2%**	**Gross Margin**	**5,421,964**	**2,988,296**	**2,433,668**	**81.4%**
				Administrative Expenses				
115,397	122,384	6,987	5 7%	Salaries, wages & employee benefits	927,862	986,895	59,033	6 0%
123	166	43	25 7%	Professional fees	1,027	1,328	301	22 7%
10,687	39,651	28,964	73 0%	Purchased services	128,837	229,708	100,871	43 9%
11,747	17,325	5,578	32 2%	Printing and postage	97,480	116,100	18,620	16 0%
2,020	2,070	50	2 4%	Depreciation & amortization	16,220	16,560	340	2 1%
17,748	4,537	(13,211)	(291 2%)	Other operating expenses	37,126	32,476	(4,650)	(14 3%)
4,237	4,666	429	9 2%	Indirect Cost Allocation, Occupancy Expense	31,160	36,149	4,989	13 8%
161,959	**190,799**	**28,840**	**15.1%**	**Total Administrative Expenses**	**1,239,711**	**1,419,216**	**179,505**	**12.6%**
				Operating Tax				
5,802	-	5,802	0 0%	Tax Revenue	45,959	-	45,959	0 0%
5,802	-	(5,802)	0 0%	Premium Tax Expense	45,959	-	(45,959)	0 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
347,253	**370,250**	**(22,997)**	**(6.2%)**	**Change in Net Assets**	**4,182,253**	**1,569,080**	**2,613,173**	**166.5%**
84.8%	***84.4%***	***(0.5%)***	***(0.6%)***	***Medical Loss Ratio***	***79.2%***	***89.1%***	***9.9%***	***11.1%***
4.8%	***5.3%***	***0.5%***	***9.4%***	***Admin Loss Ratio***	***4.8%***	***5.2%***	***0.4%***	***8.4%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2021

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				
35,115	55,000	19,885	36.2%	Purchase services	309,925	440,000	130,075	29.6%
168,178	177,250	9,072	5.1%	Depreciation & amortization	1,362,548	1,418,000	55,452	3.9%
18,423	18,500	77	0.4%	Insurance expense	147,382	148,000	618	0.4%
92,397	114,917	22,520	19.6%	Repair and maintenance	843,586	919,334	75,748	8.2%
34,168	41,250	7,082	17.2%	Other Operating Expense	384,634	330,000	(54,634)	(16.6%)
(348,281)	(406,917)	(58,636)	(14.4%)	Indirect allocation, Occupancy	(3,048,075)	(3,255,334)	(207,259)	(6.4%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – FEBRUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($53.4) thousand, unfavorable to budget $65.7 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $347.3 thousand, unfavorable to budget $23.0 thousand

CalOptima
Balance Sheet
February 28, 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$279,220,906	Accounts Payable	$32,810,569
Investments	906,605,655	Medical Claims liability	1,004,888,436
Capitation receivable	378,554,697	Accrued Payroll Liabilities	16,001,111
Receivables - Other	43,761,557	Deferred Revenue	17,647,947
Prepaid expenses	9,038,735	Deferred Lease Obligations	138,682
		Capitation and Withholds	138,485,693
Total Current Assets	**1,617,181,550**	**Total Current Liabilities**	**1,209,972,437**
Capital Assets			
Furniture & Equipment	40,923,636		
Building/Leasehold Improvements	11,375,256		
505 City Parkway West	51,628,218		
	103,927,109		
Less: accumulated depreciation	(57,365,590)		
Capital assets, net	46,561,520	Other (than pensions) post employment benefits liability	26,168,098
Other Assets		Net Pension Liabilities	27,242,277
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,263,382,811**
Cash and Cash Equivalents	(6,396,775)		
Long-term Investments	594,822,393	**Deferred Inflows**	
Total Board-designated Assets	588,425,618	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	645,524,531	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,309,267,601**	TNE	102,945,259
		Funds in Excess of TNE	947,923,329
Deferred Outflows		**TOTAL NET POSITION**	1,050,868,588
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,320,928,671**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,320,928,671**

CalOptima
Board Designated Reserve and TNE Analysis
as of February 28, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,918,099				
	Tier 1 - MetLife	159,938,922				
	Tier 1 - Wells Capital	160,081,210				
Board-designated Reserve		480,938,230	327,710,580	512,277,369	153,227,650	(31,339,138)
TNE Requirement	Tier 2 - MetLife	107,487,388	102,945,259	102,945,259	4,542,129	4,542,129
	Consolidated:	**588,425,618**	**430,655,839**	**615,222,627**	**157,769,779**	**(26,797,009)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
February 28, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	11,780,049	25,737,291
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	431,945	3,682,417
Changes in assets and liabilities:		
Prepaid expenses and other	(1,200,410)	(2,339,527)
Catastrophic reserves		
Capitation receivable	(62,195,252)	24,053,771
Medical claims liability	(201,352,531)	87,736,416
Deferred revenue	(1,963,856)	(5,775,749)
Payable to health networks	(5,034,668)	(4,495,335)
Accounts payable	12,471,741	(41,845,877)
Accrued payroll	10,701	2,842,734
Other accrued liabilities	(2,810)	(22,176)
Net cash provided by/(used in) operating activities	(247,055,091)	89,573,965
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	(115,819,432)	(182,419,343)
Change in Property and Equipment	(290,590)	(3,589,366)
Change in Board designated reserves	411,155	(3,541,725)
Change in Homeless Health Reserve	-	400,000
Net cash provided by/(used in) investing activities	(115,698,868)	(189,150,433)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(362,753,958)	(99,576,469)
CASH AND CASH EQUIVALENTS, beginning of period	$641,974,864	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**279,220,906**	**279,220,906**

BALANCE SHEET – FEBRUARY MONTH:

ASSETS of $2.3 billion decreased $184.1 million from January or 7.3%

- Operating Cash decreased $362.8 million due to disbursements for Hospital Quality Assurance Fee (HQAF)
- Investments increased $115.8 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables increased $61.3 million due to the timing of cash receipts and disbursements

LIABILITIES of $1.3 billion decreased $195.9 million from January or 13.4%

- Claims Liabilities decreased $201.4 million due to timing of claim payments and HQAF
- Accounts Payable increased $12.5 million due to the timing of quarterly premium tax

NET ASSETS of $1.1 billion, increased $11.8 million from January or 1.1%

Summary of Homeless Health Initiatives and Allocated Funds
As of February 28, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for February 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst	2021
January	Medi-Cal	Provider Relations - Printing	Sales & Marketing - Member Communication	$10,000	To reallocate funds from Public Relations - Printing to cover shortage in Sales & Marketing - Member Communications	2021
February	Medi-Cal	Human Resources - Food Service Supply	Human Resources - Cert /Cont Education	$20,000	To reallocate funds from Food Service Supply to Cert /Cont Education to fund the education reimbursement program	2021
February	Medi-Cal	Purchase Services - HPA Robot Process	Purchase Services - Burgess Group - Facilities Claims Quarterly	$63,000	To repurpose funds from HPA Robot Process to Burgess Group to cover shortfall in quarterly facilities claims fee	2021

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
April 1, 2021

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 monitoring and 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

- 2021 PACE and Medicare Parts C and D Program Audits (*applicable to OneCare, OneCare Connect and PACE*):

  On December 23, 2020, the Centers for Medicare & Medicaid Services (CMS) outlined how it will proceed with PACE and Medicare Parts C and D program audit activities in light of the ongoing public health emergency. CMS expects to proceed with program audits in calendar year 2021 and will send audit engagement letters to organizations from mid-March through September 2021 on a rolling basis. CMS will provide the same flexibilities in 2021 that were granted to audited organizations in 2020. The flexibilities include additional time to provide requested documentation, respond to questions, respond to the draft audit report, implement corrective actions, and demonstrate the correction of findings. CalOptima's Office of Compliance continues to prepare impacted stakeholders for these anticipated audits. To date, CalOptima has not been formally engaged for this audit.

- 2021 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2021. The validation audit is expected to take place starting in March and conclude in June 2021. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations

Back to Agenda

- Medicare Therapy Management (MTM) Program
- Special Needs Plan (SNP) Care Management
- Improving Drug Utilization Review (IDUR) Controls

The webinar validation is scheduled to take place on April 6, 2021.

- Contract Year (CY) 2019 Medicare Part D Improper Payment Measure (Part D IPM) (OneCare and OneCare Connect):

  On January 15, 2021, CMS informed CalOptima that its OneCare and OneCare Connect contracts have been selected to participate in the CY 2019 Medicare Part D Improper Payment Measure (Part D IPM) audit, formerly known as the Payment Error Related to Prescription Drug Event Validation (PEPV). CMS conducts the Part D IPM audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2019 payments. On January 29, 2021, CMS held an IMP training teleconference to discuss the audit process.

  On January 29, 2021, CMS informed CalOptima that it had selected two (2) PDEs for review --- one for OneCare and one for OneCare Connect. CMS will provide an opportunity for an early submission on March 19, 2021, so that any necessary corrections can be made ahead of the final deadline of April 23, 2021.

2. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

  On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. CalOptima submitted the full set of requested PDE samples to Myers & Stauffer ahead of the February 2, 2021, deadline. CalOptima has completed submission of all deliverables and is pending feedback from the auditor.

 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.

Back to Agenda

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of February 2021.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of November 2020 – January 2021 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for six (6) consecutive months for Medi-Cal expedited appeals and for five (5) consecutive months for Medi-Cal standard appeals.

Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
November 2020	98%	80%
December 2020	98%	50%
January 2021	98%	100%

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
November 2020	98%	55%
December 2020	98%	78%
January 2021	98%	61%

➢ CalOptima's Audit & Oversight (A&O) department escalated the corrective action plan (CAP) that was previously issued to an immediate corrective action plan (ICAP), as issues with non-timely processing of Medi-Cal appeals have extended to both expedited and standard appeals, appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard and expedited appeals. In addition, CalOptima's Audit & Oversight department has increased its monitoring of the GARS department by

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.

Back to Agenda

requiring case status reports twice a day and weekly updates on staffing and remediation activities.

2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	30%	0%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	0%	6.25%

➢ Based on a focused review of sixteen (16) Medi-Cal standard appeals for January 2021, all files reviewed exceeded the sixth (6th) grade reading level resulting in a low compliance score of 0% for member notice content.

➢ Based on a focused review of sixteen (16) Medi-Cal standard appeals for January 2021, fifteen (15) files did not meet the timeframe for processing a standard appeal resulting in a low compliance score of 6.25% for resolution timeliness.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved within 72 Hours of Receipt
November 2020	100%	100%	100%	10%	80%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	0%	100%

➢ Based on a focused review of four (4) Medi-Cal expedited appeals for January 2021, all files reviewed exceeded the sixth (6th) grade reading level resulting in a low compliance score of 0% for member notice content.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited appeals.

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.

Back to Agenda

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	100%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	94.4%	77.8%	77.8%

  - Based on a focused review of eighteen (18) Medi-Cal standard grievances for January 2021, the lower compliance score of 94.4% was due to one (1) member notice not being sent in the member's preferred language.
  - Based on a focused review of eighteen (18) Medi-Cal standard grievances for January 2021, the lower compliance score of 77.8% was due to incomplete resolution of four (4) grievances.
  - Based on a focused review of eighteen (18) Medi-Cal standard grievances for January 2021, the lower compliance score of 77.8% was due to untimely resolution of four (4) grievances.
  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard grievances.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
November 2020	100%	100%	100%	100%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	50%	100%	50%

[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.

Back to Agenda

- Based on a focused review of two (2) Medi-Cal expedited grievances for January 2021, the lower compliance score of 50% was due to one (1) member notice not being sent in the member's preferred language.

- Based on a focused review of two (2) Medi-Cal expedited grievances for January 2021, the lower compliance score of 50% was due to untimely resolution of one (1) grievance.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal expedited grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited grievances.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
November 2020	100%	75%	83%	100%	100%	100%	75%
December 2020	90.9%	90.9%	100%	90.9%	90.9%	100%	100%
January 2021	100%	86%	93%	93%	93%	100%	93%

- Based on a focused review of fourteen (14) Medi-Cal prior authorizations for January 2021, the lower compliance score of 86% was due to untimely resolution of two (2) standard prior authorizations.

- Based on a focused review of fourteen (14) Medi-Cal prior authorizations for January 2021, the lower compliance score of 93% was due to one (1) missing provider fax notification.

- Based on a focused review of fourteen (14) Medi-Cal prior authorizations for January 2021, the lower compliance score of 93% for clinical decision making review was due to one (1) file not following clinical hierarchy guidelines.

- Based on a focused review of fourteen (14) Medi-Cal prior authorizations for January 2021, the lower compliance score of 93% was due to one (1) file not being processed accurately.

- Based on a focused review of fourteen (14) Medi-Cal prior authorizations for January 2021, the lower compliance score of 93% for member notice content was due to one (1) file exceeding the 6th grade reading level.

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.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard Medi-Cal prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
November 2020	100%	50%	100%	100%	88%	100%	100%
December 2020	100%	90%	100%	90%	100%	100%	100%
January 2021	100%	100%	100%	100%	100%	100%	100%

- There are no significant updates to provide for the file review of Medi-Cal urgent prior authorizations for the month of January 2021.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	0%	0%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	0%	100%

- Based on a focused review of three (3) OneCare standard appeals for January 2021, all files reviewed exceeded the sixth (6^{th}) grade reading level resulting in a low compliance score of 0% for member notice content.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare

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.

Back to Agenda

standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	0%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	50%	100%

- Based on a focused review of four (4) OneCare standard grievances for January 2021, two (2) files reviewed exceeded the sixth (6th) grade reading level resulting in a low compliance score of 50% for member notice content.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard grievances.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	0%	85.71%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	0%	100%

- Based on a focused review of five (5) OneCare Connect standard appeals for January 2021, all files reviewed exceeded the sixth (6th) grade reading level resulting in a low compliance score of 0% for member notice content.

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.

Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals.

- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved within ≤ 30 Calendar Days of Receipt
November 2020	100%	100%	100%	0%	100%
December 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2021	100%	100%	100%	66.67%	100%

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for January 2021, two (2) files reviewed exceeded the sixth (6^{th}) grade reading level, one (1) file used the wrong letterhead template, one (1) file used an outdated Notice of Non-Discrimination insert, and one (1) file had an incomplete grievance resolution resulting in a low compliance score of 66.67% for member notice content.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard grievances.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
November 2020	100%	100%	90%	100%	100%	80%	0%
December 2020	100%	100%	90%	100%	100%	80%	40%
January 2021	100%	100%	70%	90%	100%	90%	100%

9 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.

Back to Agenda

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for January 2021, the lower compliance score of 70% for provider and member notification timeliness was due to the fax notification exceeding the 24-hour notification turnaround time for three (3) files.

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for January 2021, the lower compliance score of 90% was due to one (1) denial letter not being fully translated in the member's preferred language (Spanish).

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for January 2021, the lower compliance score of 90% for clinical decision making review was due to one (1) file not following clinical hierarchy guidelines.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

- OneCare Connect Utilization Management: Expedited Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
November 2020	100%	60%	90%	100%	100%	80%	0%
December 2020	100%	50%	70%	80%	100%	100%	10%
January 2021	100%	100%	80%	70%	100%	100%	90%

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for January 2021, the lower compliance score of 80% for provider and member notification timeliness was due to the fax notification exceeding the 24-hour notification turnaround time for two (2) files.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for January 2021, the lower compliance score of 70% for clinical decision making review was due to three (3) files not following clinical hierarchy guidelines.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for January 2021, the lower compliance score of 90% was due to one (1) approval letter missing pertinent approval information to the member.

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Back to Agenda

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of expedited OneCare Connect prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited prior authorizations.

5. Internal Audits: [a\]

- 2020 MedImpact Audit: Pharmacy Benefit Management Services and Pharmacy Recredentialing/Credentialing:

  - During the fourth quarter of 2020, CalOptima's Audit & Oversight (A&O) department performed an annual audit of MedImpact to assess their compliance with applicable contractual and regulatory requirements as well as industry standards for the Medi-Cal, OneCare and OneCare Connect programs.

- Pharmacy Benefit Management Services:

  - As part of the audit of MedImpact's pharmacy benefit management services, CalOptima's A&O department conducted a review of the following elements from January 1, 2019 through December 31, 2019.

Elements Reviewed	Compliance Score
Element 1: Account Management (1.01-1.02)	75.00%
Element 2: Information and Network Security (2.01-2.11)	95.45%
Element 3: Organizational Compliance Program (3.01-3.07)	100.00%
Element 4: Fraud, Waste, and Abuse (FWA) (4.04-4.06)	100.00%
Element 5: Oversight of Downstream Entities (5.01-5.07)	57.14%
Element 6: Provider Call Center Support (6.01-6.03)	100.00%
Element 7: Pharmacy Network Access and Management (7.01-7.12)	100.00%
Element 8: Benefit Implementation (8.01)	100.00%
Element 9: Eligibility Processing (9.01-9.02)	100.00%
Element 10: Claims Adjudication (10.01-10.10)	95.00%
Element 11: TrOOP and COB (11.01-11.05)	100.00%
Element 12: PDE Reporting and Reconciliation (12.01-12.04)	100.00%
Element 13: Drug Pricing and Rebate Management (13.01-13.10)	88.89%
Element 14: Formulary Administration (14.01-14.16)	96.43%
Element 15: Specialty Drug Management (15.01-15.03)	100.00%
Element 16: Utilization Management (16.01-16.07)	100.00%
Element 17: Grievances and Appeals (17.01-17.03)	75.00%
Element 18: Medicare Plan Finder (18.01-18.02)	75.00%
Element 19: Part D and Custom/Ad-hoc Reporting (19.01-19.03)	100.00%
Element 20: Member Materials (20.01-20.03)	66.67%
Element 21: Disaster and Emergency Preparedness (21.01-21.02)	100.00%
Element 22: Quality Assurance and Improvement (22.01-22.05)	100.00%

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Back to Agenda

- Findings include the following:
  - **Insufficient/incomplete audit responses:** Despite the detailed requests/requirements and multiple attempts to obtain a complete response, there were several insufficient and/or incomplete final responses provided.
  - **Lack of robust quality control practices:** Across the various functional areas, quality control processes were not consistently and formally documented, established, and/or applied.
  - **Inadequate vendor management and oversight:** Failure to properly identify and disclose downstream entities to CalOptima and document meaningful vendor management and oversight efforts such as the tracking, monitoring, and remediation of non-compliance issues. No evidence of vendor performance metrics related to quality was consistently and systematically considered in decisions to re-new/extend vendor contracts.
  - **Failure to provide rebate reports and disclosures:** MedImpact was unable to demonstrate through its responses and documentation that rebate reports were provided, as agreed upon. MedImpact failed to properly identify and disclose downstream entities to CalOptima.
  - **Insufficient resource allocation and client support:** The account executive was reported to be allocating 80% of their time to servicing CalOptima's contract as opposed to the contractual agreement of 100% and no clinical pharmacist with specific Medi-Cal experience is servicing CalOptima's account.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of MedImpact's pharmacy benefit management services. The A&O department continues to work with MedImpact and CalOptima's Pharmacy department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure deficiencies are adequately addressed.

- <u>Pharmacy Credentialing and Recredentialing:</u>
  - The review period for the pharmacy credentialing and recredentialing audit for MedImpact was from January 1, 2019 through June 30, 2020.

Elements Reviewed	Compliance Score
CR 3: Credentialing Verification	100%
CR 4: Recredentialing Cycle Length	100%

  - No findings were identified during the file and desk 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.

Back to Agenda

6. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
October 2020	83%	85%	88%	83%	93%	93%	95%	88%	93%	98%	77%	100%	100%
November 2020	85%	94%	97%	93%	84%	92%	93%	89%	95%	99%	60%	100%	97%
December 2020	86%	96%	97%	86%	91%	95%	96%	82%	94%	99%	97%	89%	97%

- Based on a focused review of select files, nine (9) health networks drove the lower compliance score for timeliness for December 2020. Of the eighty-three (83) files received from the nine (9) health networks, twenty-six (26) files were deficient for timeliness. Deficiencies for the lower timeliness scores were due to the following:
  - Failure to meet timeframe for decision (5 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of December 2020. Of the twenty-one (21) files received from the two (2) health networks, fourteen (14) files were deficient due to failure to cite criteria for decision.

- 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.

Back to Agenda

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2020	92%	98%	99%	94%
November 2020	88%	85%	90%	85%
December 2020	95%	97%	97%	92%

- Overall scores for Medi-Cal claims increased across all areas for the December 2020 file review.

- 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.

7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): 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
October 2020	93%	100%	95%	98%	97%	100%	97%	99%
November 2020	94%	Nothing to Report	80%	100%	92%	84%	93%	100%
December 2020	100%	100%	91%	100%	91%	100%	92%	93%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of December 2020. Of the eleven (11) files submitted by the two (2) health networks, two (2) files were deficient due to failure to cite criteria for decision.

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.

Back to Agenda

- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score during the month of December 2020. Of the twenty-three (23) files received from the four (4) health networks, nine (9) files were deficient for letter language. The deficiencies for the lower letter score were due to the following:
  - Failure to use appropriate CMS logo
  - Failure to provide letter with description of services in lay language

- 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 Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2020	100%	100%	100%	96%
November 2020	88%	86%	88%	88%
December 2020	96%	96%	99%	100%

- Overall scores for OneCare claims increased across all areas for the December 2020 file review.

- 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.

Back to Agenda

8. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
October 2020	88%	93%	92%	97%	94%	85%	87%	96%	83%	92%	99%
November 2020	83%	98%	95%	98%	92%	84%	85%	95%	77%	92%	100%
December 2020	95%	87%	96%	88%	94%	81%	83%	90%	85%	95%	97%

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for timeliness during the month of December 2020. Of the thirty-three (33) files submitted by the three (3) health networks, six (6) files were deficient for timeliness. Deficiencies for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision
  - Failure to meet timeframe for provider initial notification
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, six (6) health networks drove the lower compliance score for clinical decision making (CDM) during the month of December 2020. Of the ten (10) files submitted by the six (6) health networks, seven (7) files were deficient for CDM. The lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
  - Failure to include appropriate professional who makes decision
  - Failure to obtain adequate clinical information

- Based on a focused review of select files, four (4) health networks drove the lower compliance letter score during the month of December 2020. Of the seven (7) files submitted by the four (4) health networks, four (4) files were deficient for letter language. Deficiencies for the lower letter scores were due to the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify
  - Failure to provide referral back to primary care provider (PCP) on denial letter

- 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

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.

Back to Agenda

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
October 2020	97%	98%	100%	99%
November 2020	87%	85%	90%	91%
December 2020	93%	94%	99%	97%

➢ Overall scores for OneCare Connect claims increased across all areas for the December 2020 file review.

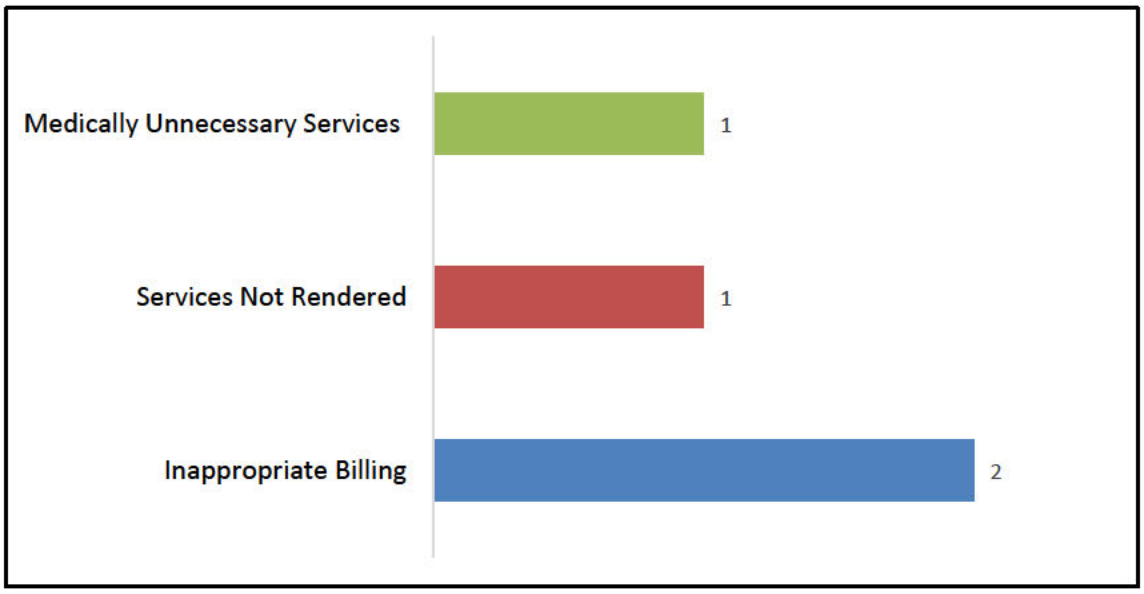
➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies 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 policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

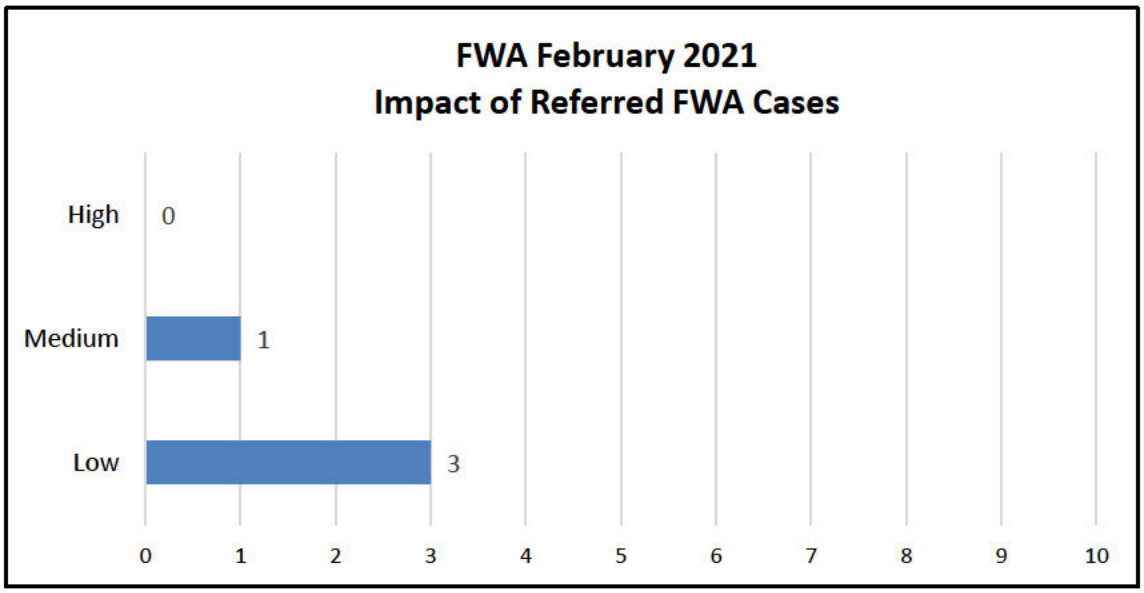
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in February 2021)



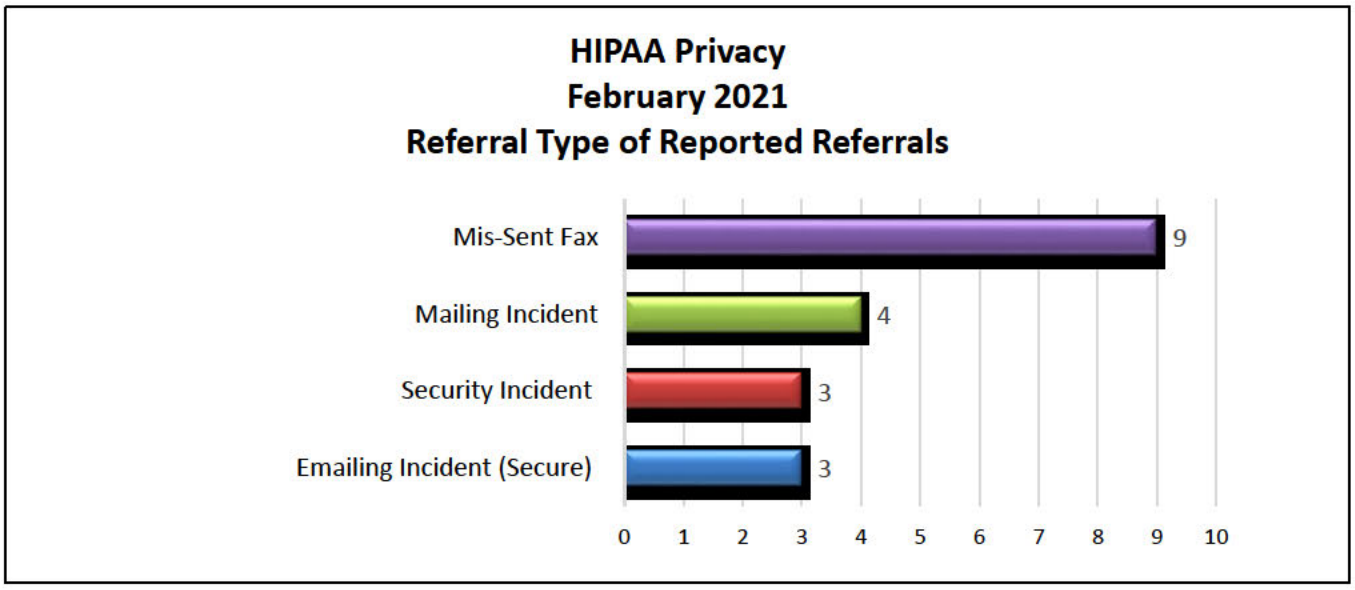


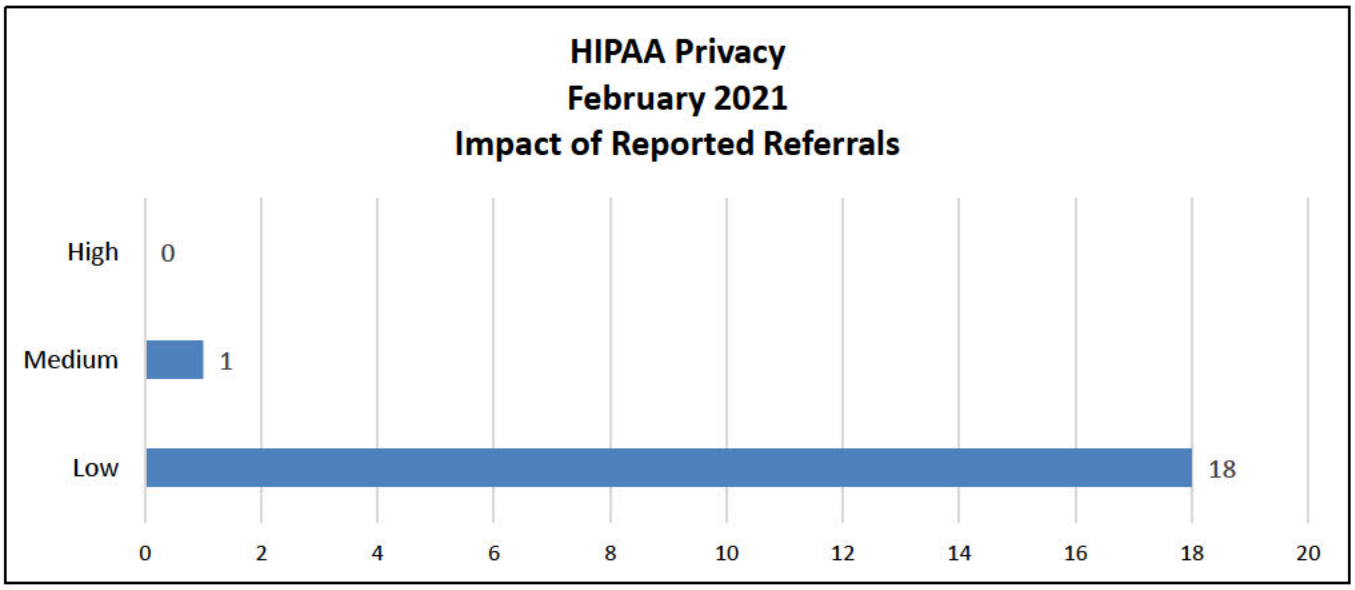
Total Number of New Cases Referred to DHCS (State)	4
Total Number of Closed Cases Referred to I-MEDIC (CMS)	0
Total Number of Referrals Reported	**4**

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.

Back to Agenda

E. Privacy Update: (February 2021)





Total Number of Referrals Reported to DHCS (State)	19
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**19**

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.

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

March 15, 2021

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: April Board of Directors Report

The President signed a $1.9 trillion COVID-19 relief package last week that makes a number of Medicaid-related changes and directs billions of dollars to ongoing vaccination efforts and other pandemic response activities. Meanwhile, Congress is already looking ahead to the fiscal 2022 appropriations process and a likely return of earmarks. This report covers developments through March 14, 2021.

COVID-19 Relief Legislation

On March 11, President Biden signed into law the American Rescue Plan Act of 2021 (P.L. 117-2). The House passed the Senate-approved version of the legislation by a 220-211 vote on March 10. No Republicans supported the bill, and one Democrat, Rep. Jared Golden (D-ME), opposed the bill. Rep. Kurt Schrader (D-OR), who previously voted against the bill, voted to support the measure.

The Act provides for a total of $1.88 trillion in federal investments, including funding for: direct payments to individuals and families; extending enhanced unemployment benefits; extending tax credits for employers offering paid leave; COVID-19 testing and vaccine activities; and the safe reopening and operation of schools.

While the House version of the American Rescue Plan initially included a provision to increase the federal minimum wage to $15, this language was removed by the Senate after it was determined that the item did not meet budget reconciliation requirements. The amended Senate version includes $8.5 billion in funding for rural health care providers. Senators also increased the temporary Federal Medical Assistance Percentages (FMAP) bump for home- and community-based services from 7.35 percentage points to 10 percentage points, and delayed until 2024 the elimination of the Medicaid drug rebate cap. The final package also includes:

- Mandatory coverage of COVID-19 vaccines, vaccine administration, and treatment under Medicaid;
- Flexibility for states to extend Medicaid eligibility to women for 12 months postpartum;
- Enhanced Federal Medical Assistance Percentages (FMAP) for bundled community-based mobile crisis intervention services;

Back to Agenda

- Temporary FMAP increase of five percentage points for states that newly expand Medicaid; and
- Extension of 100 percent FMAP for services provided to Medicaid beneficiaries receiving care through Urban Indian Organizations and Native Hawaiian Health Care Systems.

The American Rescue Plan allocates $7.5 billion for the Centers for Disease Control and Prevention (CDC) to prepare, promote, administer, monitor and track vaccines, and provides nearly $48 billion for a national COVID-19 testing strategy and related activities. The Act provides nearly $220 billion in COVID-19 relief for states, territories, and tribal governments, along with $130 billion for metropolitan cities, municipalities, and counties. In addition, the package includes more than $25 billion in relief for small and medium-sized restaurants.

Meanwhile, the House is expected to vote soon on bipartisan legislation that would extend the Paycheck Protection Program for two months to May 31.

FY 2022 Budget/Appropriations

Beset by delays stemming from the presidential transition, the Office of Management and Budget (OMB) is not expected to release the President's Fiscal Year (FY) 2022 until May. Nonetheless, House Democrats are moving forward with the annual appropriations process, which may see the return of congressional earmarks. New guidelines released by House Appropriations Committee Chairwoman Rosa DeLauro (D-CT) stipulate that such "community project funding" cannot flow to for-profit entities. In addition, Members can submit a maximum of 10 project funding requests across the various appropriations subcommittees. The Appropriations Committee set mid-April deadlines for Members to submit their funding requests to the subcommittees. The House Labor-HHS Subcommittee has a deadline of April 14.

Senate Democrats have agreed in principle to allow earmarks, though the upper chamber's rules could differ from the House's requirements. In addition, Republican leaders have not yet said whether they will support earmarks, which would require a change to conference rules.

Telehealth

On February 23, Sens. Tim Scott (R-SC), Brian Schatz (D-HI), and Jeanne Shaheen (D-NH) reintroduced the bipartisan Telehealth Modernization Act (S. 368). The legislation would permanently eliminate Medicare's geographic and originating site restrictions; allow the Secretary of Health and Human Services to expand the types of practitioners who can provide Medicare-covered telehealth services; permanently allow federally qualified health centers (FQHCs) and rural health clinics to serve as eligible distant sites for telehealth services; and

permanently allow the use of telehealth for face-to-face assessments and encounters for home dialysis and hospice care, as clinically appropriate. A House companion bill (H.R. 1332) was introduced by Reps. Buddy Carter (R-GA) and Lisa Blunt Rochester (D-DE).

On March 2, the House Energy and Commerce Committee's Health Subcommittee held a hearing to discuss the future of telehealth. Members on both sides of the aisle, including Subcommittee Chairwoman Anna Eshoo (D-CA), called for making permanent many of the telehealth flexibilities that were enacted during the COVID-19 pandemic. Subcommittee Ranking Member Brett Guthrie (R-KY) noted that broadband access is still a limiting factor in many areas, while Full Committee Chairman Frank Pallone (D-NJ) expressed concerns that telehealth may encourage overutilization.

Public Charge Rule

On March 11, the Biden Administration issued a final regulation that formally vacates the "public charge" rule. The controversial rule, issued by the Trump Administration in 2019, gave the federal government additional authorities to deny residency applications for immigrants who have received or are considered likely to receive public assistance, such as Medicaid. The Supreme Court also recently dismissed several cases challenging the rule after the Department of Justice stated it would no longer defend the regulation.

Secretary of Homeland Security Alejandro N. Mayorkas said in a statement that the Department has "closed the book on the public charge rule" and will be working in the coming weeks "to ensure immigrants and their families have accurate information about our public charge policies." Studies over the past year found evidence of a sharp drop in immigrants' utilization of public assistance, seeming to confirm advocates fears of a "chilling effect" on enrollment in Medicaid and other programs.

Vaccine Update

New cases of COVID-19 and COVID-associated hospitalizations are down from the early January peak in the United States, and virus-related deaths are averaging about 1,300 per day. While experts are encouraged by the significant drop in cases over the last month, there is increasing concern from the Administration about the stagnation in weekly cases over the past week. As vaccination rates continue to increase across the country, there is growing recognition that the virus variants and discontinuation of state mask mandates pose a risk to recent progress.

More than 37 million Americans are now fully vaccinated, and the U.S. is averaging more than 2 million doses a day. On February 27, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for a third COVID-19 vaccine, manufactured by Johnson

& Johnson. President Biden announced on March 2 that Merck will help produce the vaccine, with both companies receiving assistance from the federal government in these efforts. The President pledged that the U.S. will produce enough doses to vaccinate every adult by May. On March 11, President Biden announced that he will direct states to make COVID-19 vaccines available to all American adults no later than May 1. In a move to support school reopenings, the Department of Health and Human Services (HHS) on March 2 sent a letter to states, directing them to prioritize teachers and educators for vaccinations.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

March 12, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

This week, Governor Newsom delivered the annual State of the State Address two months later than usual and hundreds of miles from its typical location in the State Capitol.

For lobbyists, legislative staff, and legislators, the State of the State is usually just another routine event that marks the start of a busy year in the Legislature. The Senate and Assembly convene together in the Assembly chamber to hear the Governor's address.

While portions of the speech are picked up by news outlets, it is usually little more than an opportunity for the Governor to lay out their priorities for the coming year. The address usually tracks closely with the Governor's budget priorities. Often enough Democrats in the legislature introduce bills that align with the Governor's priorities. Sometimes the Governor's priorities shift, and what was important in January languishes by June. By February, the Capitol has largely moved on from the event. 2021's address was different for two big reasons.

First, the venue and format were different given social distancing requirements. More on that later.

Second, the Governor seems increasingly likely to be facing a recall election in 2021. This week, proponents announced the collection of 1.9 million signatures. Proponents must collect about 1.5 million by March 17 for the recall to qualify. While not all collected signatures have been verified by election officials, the large margin of "extra" signatures likely means the recall will qualify. The 2021 State of the State was an opportunity for the Governor to rebut his opponents in the recall election.

The speech, which in recent years has been delivered mid-day, was delivered from Dodger Stadium at six in the evening. The 56,000-seat stadium, which is currently serving as a mass vaccination site, served as an explicit reminder of the number of Californians who have died as a result of the pandemic.

The Governor took the opportunity to speak directly to California voters, promoting and defending his own record. The Governor's vocabulary can be technical and his speeches, which sometimes last well over an hour, can be very detailed. By contrast, the Governor's Address Tuesday was succinct and disciplined. He touted his Administration's first in the nation stay-at-home order and efforts to ramp up hospital capacity while reminding voters that the state was in position to provide ventilators and protective equipment to other parts of the Country. While he acknowledged that "progress hasn't always felt fast enough," the Governor noted that 10.6 million Californians have been vaccinated.

In recent weeks, the most effective criticism leveled at the Governor has centered on the fact that many schools remain closed today. Governor Newsom reminded viewers that he recently brokered a deal to incentivize school reopening. Tuesday night's event opened with a reading of the pledge of allegiance by a masked elementary school student from inside of a classroom.

At the same time, the Governor took the opportunity to speak to the core constituencies he will need to stand by him during the recall election. A nurse sung the National Anthem surrounded by healthcare workers. The Address itself was peppered with praise for teachers, healthcare workers, grocery workers, and parents. Equity was also a core component of the Address. Governor Newsom acknowledged that the pandemic has hit Latino and African American communities hard, and touted his recent plan to set aside 40% of vaccines for low-income communities.

While subtle, the Governor also addressed the recall itself saying "To the California critics out there who are promoting partisan political power grabs with outdated prejudices, and rejecting everything that makes California truly great, we say this: We will not be distracted from getting shots in arms, and our economy booming again. This is a fight for California's future." The statement was met with applause from the numerous Democratic legislators, statewide officeholders, and local officials projected on screens behind the Governor.

Time will tell how effective the address was, but it is hard not to see it, at least partially, as an important moment at the beginning of a campaign. As if to underscore the point, once the Address concluded the Governor and First Partner exited the stage to the sounds of Wilco's version of "California Stars." You may remember that the song was featured in Governor Newsom's 2018 campaign commercials.

Back to Agenda

2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 454 Rodriguez	**Provider Supplemental Payments:** Would allow the Department of Managed Health Care (DMHC) to require health plans to provide supplemental payments and/or nonmonetary support to providers during and for 60 days after a public health emergency or disaster declaration. DMHC may require health plans to provide rate increases, one-time payments, interest-free loans, personal protective equipment, and/or other equipment and business expenses. Plans must include any payments in their medical loss ratio calculation as a direct patient care expense.	**02/08/2021** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose
SB 242 Newman	**Provider Reimbursement for Medically Necessary Equipment:** Would allow physicians and dental providers to be reimbursed for medically necessary equipment to treat and reduce the spread of COVID-19 or other infectious diseases in the workplace. Reimbursable equipment would include personal proactive equipment, infection control supplies, testing and diagnostic supplies, contact tracing, or other related information technology expenses. The reimbursement rates would be determined by the Department of Health Care Services (DHCS).	**01/21/2021** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 77 Petrie-Norris	**Jarrod's Law:** States the intent of the author to introduce legislation that would require DHCS to administer a licensing process for inpatient and outpatient substance use disorder treatment programs that are not otherwise required to be licensed under current law.	**12/07/2020** Introduced	CalOptima: Watch
AB 822 Rodriguez	**Emergency Psychiatric Observations:** Would add outpatient psychiatric observation services as a covered Medi-Cal nonspecialty mental health benefit, when necessary, for emergency psychiatric treatment. Medi-Cal managed care plans (MCPs) would be required to reimburse the observing provider.	**02/16/2021** Introduced	CalOptima: Watch
AB 942 Wood	**Medically Necessary Services:** Similar to SB 279, would allow Medi-Cal to provide reimbursement for clinically appropriate and covered behavioral health benefits before a diagnosis.	**02/17/2021** Introduced	CalOptima: Watch
AB 988 Bauer-Kahan, Berman, Chiu, Quirk-Silva, Ting	**988 Crisis Hotline:** No later than July 16, 2022, would implement the state's 988 Crisis Hotline using the digits 9-8-8 established by federal law as the National Suicide Prevention Lifeline. The 988 Crisis Hotline would connect individuals experiencing a mental health crisis with suicide prevention and mental health crisis counselors.	**02/18/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 75 Bates	**Southern California Fentanyl Task Force:** Would establish the Southern California Fentanyl Task Force, under the direction of the Attorney General, to identify strategies to combat the fentanyl crisis. The task force would include representatives from the California Department of Justice (DOJ), California Highway Patrol and each county within Southern California. Would require the task force to hold its first meeting by July 1, 2022, and issue a report of its findings and recommendations to the Legislature and DOJ by January 1, 2025.	**02/15/2021** Introduced	CalOptima: Watch
SB 106 Umberg	**Mental Health Services Act (MHSA) Focus Populations:** States the intent of the author to introduce legislation that would update the MHSA to further address individuals with mental illness who are also experiencing homelessness or are involved in the criminal justice system. Updates to the MHSA would also address early intervention efforts for youth experiencing a mental illness.	**01/05/2021** Introduced	CalOptima: Watch
SB 221 Wiener	**Timely Access to Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment—in alignment with the current time frame for the initial appointment. Although this bill would modify the Knox-Keene Act, which does not apply to CalOptima, DHCS would be expected to align standards in the Medi-Cal managed care contracts in accordance with current practice.	**01/13/2021** Introduced	CalOptima: Watch
SB 279 Pan	**Medically Necessary Services:** Similar to AB 942, would allow Medi-Cal to provide reimbursement for clinically appropriate and covered behavioral health benefits before a diagnosis.	**01/29/2021** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 875 Wood	**CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS):** Similar to SB 256, would require ECM to be added as a covered benefit for Medi-Cal beneficiaries. This would include the coordination of all primary, acute, behavioral, oral, and long-term services and supports (LTSS). Additionally, would require a Medi-Cal MCP to list available ILOS on its website and in the beneficiary handbook as well as share data with DHCS related to beneficiary utilization of ILOS. ILOS offered by the health plan must be incorporated into DHCS' methodology for calculating the MCP's capitation rate.	**02/17/2021** Introduced	CalOptima: Watch
AB 1160 Rubio	**Medically Tailored Meals:** Would allow Medi-Cal MCPs to offer medically tailored meals to beneficiaries as an ILOS, effective January 1, 2022.	**02/18/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 256 Pan	**CalAIM ECM and ILOS:** Similar to AB 875, would require ECM to be added as a covered benefit for Medi-Cal beneficiaries. This would include the coordination of all primary, acute, behavioral, oral, and LTSS. Additionally, would require a Medi-Cal MCP to list available ILOS on its website and in the beneficiary handbook as well as share data with DHCS related to beneficiary utilization of ILOS. ILOS offered by the health plan must be incorporated into DHCS' methodology for calculating the MCP's capitation rate.	**01/26/2021** Introduced	CalOptima: Watch
RN 21 08858 Trailer Bill	**CalAIM:** Would codify various provisions of the CalAIM Proposal as revised by DHCS on January 8, 2021, for which implementation requires changes in state law.	**02/01/2021** Published on the Department of Finance website	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include a food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, CHIP and Medicaid, as a mandatory benefit.	**01/04/2021** Introduced	CalOptima: Watch
AB 114 Maienschein	**Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit for any beneficiary who is at least 1 year of age and is receiving inpatient services in an intensive care unit. The benefit would include individual sequencing, trio sequencing for one or more parent and their baby, and ultra-rapid sequencing.	**12/17/2020** Introduced	CalOptima: Watch
AB 342 Gipson	**Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for all colorectal cancer screenings and laboratory tests recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, would prohibit health plans from imposing cost sharing on colonoscopies for those between 50 and 75 years of age. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider.	**01/28/2021** Introduced	CalOptima: Watch
AB 797 Wicks	**Infertility Treatment:** Effective January 1, 2022, would require all health plans to provide coverage for infertility treatments, including in vitro fertilization, to any beneficiary who is unable to reproduce. Would also remove coverage exemptions for religiously affiliated health plans and employer sponsors.	**02/16/2021** Introduced	CalOptima: Watch
SB 245 Gonzalez	**Abortion Services:** Would prohibit a health plan from imposing a deductible, coinsurance, copayment or Medi-Cal cost-sharing on all abortion services, including any follow-up care, provided as of January 1, 2022. Likewise, a health plan may not require a prior authorization or impose an annual or lifetime limit on such coverage.	**01/22/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home, FDA-approved STD test kits and any associated laboratory fees. Subject to funding by the State Legislature, would also authorize Medi-Cal reimbursement for STD-related services at the same rate as comprehensive family planning services, even when the patient is not at risk of becoming pregnant or in need of contraception.	**02/04/2021** Introduced	CalOptima: Watch
RN 21 05566 Trailer Bill	**Delayed Suspension of Medi-Cal Adult Optional Benefits:** Would delay the suspension of certain Medi-Cal adult optional benefits, which are currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Extended optional benefits include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch
RN 21 05595 Trailer Bill	**Delayed Suspension of Medi-Cal Postpartum Care Extension:** Would delay the suspension of Medi-Cal postpartum expanded eligibility, which is currently set to expire on December 31, 2021, by 12 additional months through December 31, 2022. Postpartum expanded eligibility allows Medi-Cal beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition, to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. Upon the discontinuation of postpartum expanded eligibility on December 31, 2022, postpartum care would terminate 60 days after the last day of pregnancy.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

MEDI-CAL ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office previously projected this expansion would cost approximately $900 million General Fund (GF) in 2019–20 and $3.2 billion GF each year thereafter, including the costs of In-Home Supportive Services.	**12/07/2020** Introduced	CalOptima: Watch
AB 112 Holden	**Inmate Eligibility Extension:** Would delay the termination date of Medi-Cal eligibility for non-juvenile inmates from one year of elapsed incarceration to three years of elapsed incarceration. For juvenile inmates, Medi-Cal eligibility would not be terminated until three years after their status as a juvenile has ended. While Medi-Cal benefits and payments would still be suspended throughout incarceration, as required by federal law, this bill would allow inmates to remain Medi-Cal eligible for a longer period before termination. The lengthened eligibility period would allow more inmates to immediately reinstate their benefits upon release, rather than initiate the standard redetermination process.	**12/17/2020** Introduced	CalOptima: Watch
AB 470 Carrillo	**Elimination of Asset Consideration:** States the intent of the author to introduce legislation that would prohibit the consideration of an individual's assets when determining Medi-Cal eligibility.	**02/08/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 56 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 GF, $21 million federal funds) for approximately 25,000 undocumented seniors. In-Home Supportive Services are estimated to cost $13 million GF.	**12/07/2020** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 685 Maienschein	**Claims Processing Timeline:** Would shorten the timeline for health plans to process submitted claims from 30 days to 15 days. The separate timeline for health maintenance organizations (HMOs) would remain at 45 days.	**02/16/2021** Introduced	CalOptima: Watch
AB 862 Chen	**Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning July 1, 2022. Would require DHCS to calculate the annual QAF for a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period.	**02/17/2021** Introduced	CalOptima: Watch
AB 1050 Gray	**Medi-Cal Beneficiary Communications Consent:** Would amend the application for Medi-Cal benefits to include a written consent to receive all forms of communications from DHCS, county welfare departments, MCPs, and providers regarding the beneficiary's care or benefits.	**02/18/2021** Introduced	CalOptima: Watch
AB 1082 Waldron	**California Health Benefits Review Program (CHBRP) Extension:** Would extend current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed states legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill would also increase the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022.	**02/18/2021** Introduced	CalOptima: Watch
AB 1107 Boerner Horvath	**In-Network Ground Emergency Medical Transportation (GEMT):** Effective January 1, 2022, would require health plans covering GEMT to include those services as an in-network benefit.	**02/18/2021** Introduced	CalOptima: Watch
AB 1131 Wood	**Health Information Exchange:** Would require health plans, hospitals, medical groups, testing laboratories and nursing facilities to participate in a health information exchange network, no later than January 1, 2023, to increase access to electronic health records for every patient and beneficiary.	**02/18/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1162 Villapadua	**Claims Processing Timeline; Prior Authorizations During Emergency:** Would shorten the timeline for health plans to process submitted claims from 30 days (or 45 days for HMOs) to 20 days for all health plans. Additionally, would allow DMHC to suspend health plan requirements for prior authorizations in any county where a declared state of emergency has impacted beneficiaries or providers.	**02/18/2021** Introduced	CalOptima: Watch
AB 1355 Levine	**Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system for Medi-Cal MCPs, effective January 1, 2022. The bill would also provide every Medi-Cal beneficiary filing a grievance with access to an IMR.	**02/19/2021** Introduced	CalOptima: Watch
AB 1400 Kalra, Lee, Santiago	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards, including CHIP, Medi-Cal, ancillary health care or social services covered by regional centers for people with developmental disabilities, Knox-Keene, and Medicare.	**02/19/2021** Introduced	CalOptima: Watch
SB 250 Pan	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2023, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for two years. A provider would qualify if their number of denied prior authorizations requests (which were not appealed or were lost upon appeal) are both within a certain range of the average numbers for the same specialty in the same region. Every two years, the plan would audit 10% of the provider's records to redetermine qualification for "deemed approved" status.	**01/25/2021** Introduced	CalOptima: Watch CAHP: Oppose
RN 21 08473 Trailer Bill	**Delayed Proposition 56 Suspensions:** Would delay the suspension of certain value-based payment (VBP) programs authorized under Proposition 56, which are currently set to expire on July 1, 2021. For VBP programs aimed at improving behavioral health integration, DHCS would suspend payments after spending a total of $95 million. For all other VBP programs, DHCS would suspend payments on July 1, 2022.	**02/04/2021** Published on the Department of Finance website	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 523 Nazarian	**Program of All-Inclusive Care for the Elderly (PACE) Flexibilities:** Would make permanent specified PACE program flexibilities instituted, on or before January 1, 2021, in response to the state of emergency caused by COVID-19.	**02/10/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 540 Petrie-Norris	**PACE Enrollment Process:** Would seek to increase enrollment for PACE organizations. However, this would: ■ Exempt current PACE participants from enrolling in a Medi-Cal MCP; ■ Permit PACE to be listed as a Medi-Cal/Medicare plan choice, similar to the existing two-plan model; ■ Delay mandatory or passive enrollment into MCPs by up to 60 days for new Medi-Cal beneficiaries age 55 and over or who express interest in PACE; and ■ Require DHCS to establish an auto-referral program for those who may be eligible for PACE upon Medi-Cal enrollment. Of note, a PACE organization may provide care for a potential participant at their own financial risk while that individual is being assessed for PACE eligibility.	**02/10/2021** Introduced	CalOptima: Watch
AB 911 Nazarian	**Master Plan on Aging LTSS:** Similar to SB 515, would establish the California LTSS Benefits Board. This Board would be required to establish a subcommittee that would provide ongoing recommendations for the Master Plan on Aging.	**02/17/2021** Introduced	CalOptima: Watch
AB 1083 Nazarian	**Senior Affordable Housing Nursing Pilot Program:** Would require the California Department of Aging to establish and administer the Housing Plus Services Nursing Pilot Program in the counties of Los Angeles, Orange, Riverside, Sacramento and Sonoma. The program would provide grant funds to qualified nonprofit organizations that specialize in resident services for the purposes of hiring one full-time registered nurse to work at three senior citizen housing developments in each county. The registered nurse would be required to provide health education, navigation, coaching and care to residents.	**02/18/2021** Introduced	CalOptima: Watch
SB 515 Pan	**Master Plan on Aging LTSS:** Similar to AB 911, would establish the California LTSS Benefits Board. This Board would be required to establish a subcommittee that would provide ongoing recommendations for the Master Plan on Aging.	**02/17/2021** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 671 Wood	**Disease Management Payment for Specialty Drugs:** Would allow DHCS to provide a supplemental disease management payment to contracted pharmacies for dispensing specialty drugs to ensure beneficiary access.	**02/12/2021** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 278 Flora	**Medi-Cal Enrollment for Podiatrists:** Would apply current Medi-Cal provider enrollment processes for a physician to a doctor of podiatric medicine. This would require DHCS to process applications from podiatrists within 90 days instead of 180 days as well as allow podiatrists to use the short form application and change of location options.	**01/19/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 882 Gray	**Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program:** Effective January 1, 2022, would restrict eligibility for loan payment assistance under the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which is currently available to recently graduated physicians and dentists who serve Medi-Cal beneficiaries, to only those who practice in federally designated health professional shortage areas. Would indefinitely extend the program beyond its current termination date of January 1, 2026.	**02/17/2021** Introduced	CalOptima: Watch
SB 365 Caballero	**Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would require Medi-Cal reimbursement for any specialist provider, including a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), who provides an e-consult service to a requesting provider treating a Medi-Cal beneficiary. This may include assessing health records, providing feedback and/or recommending a further course of action. DHCS would be required to establish a reimbursement rate consistent with federal Medicare policy.	**02/10/2021** Introduced	CalOptima: Watch

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 265 Petrie-Norris	**Laboratory Services Reimbursement:** Would remove the current requirement that DHCS cannot reimburse Medi-Cal fee-for-service providers for clinical laboratory or laboratory services at a rate that exceeds 80% of the lowest maximum allowance established by the federal Medicare program for the same service. Federal legislation enacted in 2018 established new Medicare rates for lab services, which resulted in automatic cuts to Medi-Cal reimbursement rates that are now often below the cost of service.	**01/15/2021** Introduced	CalOptima: Watch
SB 316 Eggman	**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 does not allow an FQHC to be reimbursed for 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 of whether the visits were at the same location on the same day. As a result, a patient would no longer be required to wait for 24 hours between medical and dental or mental health services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**02/04/2021** Introduced	CalOptima: Watch LHPC: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 71 Rivas, Luz	**Bring California Home Act:** Would create the Bring California Home Fund in the State Treasury to fund a statewide homelessness solutions program. Funds would be derived from specified rate increases and other adjustments in the personal income tax and corporate income tax structures. Would authorize the Homeless Coordinating and Financing Council and the Department of Housing and Community Development to jointly administer the funds to applicants, including counties, cities and developers, for the purpose of reducing the number of individuals experiencing homelessness. Eligible uses of funding would include rental assistance, landlord incentives, housing navigation services, and the development and operation of permanent affordable housing and transitional housing projects.	**12/07/2020** Introduced	CalOptima: Watch
AB 362 Quirk-Silva	**Homeless Shelter Safety:** States the intent of the author to introduce legislation that would require homeless shelters receiving certain grants to comply with health and safety regulations to improve the shelters' condition.	**02/01/2021** Introduced	CalOptima: Watch
AB 369 Kamlager	**Presumptive Eligibility and Street Medicine Payment:** Would require DHCS to apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Hospitals would be permitted to determine presumptive eligibility. Would also require DHCS to establish a Medi-Cal fee-for-service payment system to reimburse providers who deliver on-street medical services to individuals experiencing homelessness. Such services would not need to be provided by or require a referral from an assigned primary care physician. DHCS would issue a benefits identification card to those receiving services, but providers would not be required to verify the identity of the individual at the time of service. Additionally, would prohibit DHCS from requiring prior authorization or other utilization management of any services related to COVID-19, including testing, treatment, and prevention, through January 1, 2026.	**02/01/2021** Introduced	CalOptima: Watch
AB 1009 Bloom	**Farm to School Food Hub Program:** Would establish the Farm to School Hub Program within the California Department of Food and Agriculture. The program would incentivize the creation of third-party "farm to food hubs" to distribute food from local farms to public schools, food banks, and other public and nonprofit organizations. Grants of $150,000 each would be awarded to nine hubs by December 15, 2022; grants of $5 million each would be awarded to three hubs by December 31, 2023.	**02/18/2021** Introduced	CalOptima: Watch
AB 1372 Muratsuchi	**Temporary Shelters:** Would require every city or county to provide every person who is experiencing homelessness with temporary shelter, access to mental treatment, and resources for job placement and training until the individual is placed in permanent housing. If the use of a temporary shelter is unavailable, that city or county would be required to provide a rent subsidy to that individual.	**02/19/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 17 Pan	**Office of Racial Equity:** Would create the independent Office of Racial Equity to develop a Racial Equity Framework containing guidelines and strategies for advancing racial equity across the state government. Each state agency, including DHCS, would be required to implement a Racial Equity Plan in alignment with the goals of the framework, and the office and each agency would prepare annual reports outlining progress toward achieving those goals.	**12/07/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would permit the U.S. Secretary of Health and Human Services to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions.	**01/19/2021** Introduced	CalOptima: Watch
S. 150 Cortez Masto	**Ensuring Parity in Medicare Advantage for Audio-Only Telehealth Act of 2021:** Would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage plans during the COVID-19 public health emergency.	**02/02/2021** Introduced	CalOptima: Watch
AB 32 Aguiar-Curry	**Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal MCPs, including County Organized Health Systems, to reimburse its contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal MCP, such as contracted health networks. Likewise, clinics must be reimbursed by Medi-Cal for telehealth services at the same rate as in-person services. Would also allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services. Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic. DHCS would be required to establish an advisory group to guide the development a long-term Medi-Cal telehealth policy.	**12/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 935 Maienschein	**Behavioral Health Telehealth Consultation Program:** Would create a provider-to-provider telehealth consultation program for use when assessing mental health and/or providing mental health treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2022. Would permit telehealth services to be conducted by video or audio-only calls. Additionally, would require the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would require access to a psychiatrist when deemed appropriate or requested by the treating provider.	**02/17/2021** Introduced	CalOptima: Watch
RN 21 08394 Trailer Bill	**Medi-Cal Telehealth Proposal:** Would modify, extend or expand certain telehealth flexibilities adopted by DHCS during the COVID-19 pandemic to be incorporated into permanent law. Would allow FQHCs and RHCs to establish a patient within its federal designated service area through audio-visual telehealth. However, health care providers would be prohibited from establishing a patient through audio-only telehealth or other non-audio-visual telehealth modalities. Would also require DHCS to specify the Medi-Cal-covered health care benefits that may be delivered through telehealth services. DHCS and Medi-Cal MCPs would be required to reimburse audio-visual telehealth services at the same rate as in-person services, while audio-only, remote patient monitoring and other modalities may be reimbursed at different rates. Additionally, would allow Medi-Cal MCPs to include telehealth services when determining compliance with network adequacy standards without the use of alternative access standard requests.	**02/02/2021** Published on the Department of Finance website	CalOptima: Watch

YOUTH SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**CARING for Kids Act:** Would permanently extend authorization and funding of the Children's Health Insurance Program (CHIP) and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs.	**01/04/2021** Introduced	CalOptima: Watch
AB 382 Kamlager	**Whole Child Model (WCM) Program Stakeholder Advisory Group:** Would extend the duration of the California Children's Services Advisory Group, which is currently scheduled to end on December 31, 2021, for an additional two years through December 31, 2023.	**02/02/2021** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 393 Reyes	**Early Childhood Development Act of 2020:** Effective immediately, would require the California Department of Social Services (CDSS) to conduct an evaluation of emergency childhood services provided during the COVID-19 public health emergency, including the following: ■ Availability of crisis childcare services ■ Availability of COVID-19 testing and personal protective equipment ■ Vaccination prioritization and distribution ■ Cleaning of childcare centers ■ Payment to family childcare homes during state-mandated closures ■ Foster care programs CDSS would be required to submit its findings and associated recommendations to the State Legislature by October 1, 2021.	**02/02/2021** Introduced	CalOptima: Watch
AB 1117 Wicks	**Healthy Start: Toxic Stress and Trauma Resiliency for Children Program:** Would establish the Healthy Start: Toxic Stress and Trauma Resiliency for Children Program (Program). The Program would award grants to qualifying schools, local educational agencies (LEAs), and other entities serving students, to fund support services for students and their families. Grants awarded would be for no more than $500,000 each and matched by the grantee with $1 for each $2 awarded. Would also require the State Department of Education and DHCS to establish the Children's Coordinated Services Response Team to encourage the integration of children's services at the local level and to promote community resiliency.	**02/18/2021** Introduced	CalOptima: Watch
SB 428 Hurtado	**Adverse Childhood Experiences Screenings (ACEs):** Would require a health plan to provide coverage for ACEs.	**02/12/2021** Introduced	CalOptima: Watch
SB 508 Stern	**Mental Health Coverage at Schools:** Would authorize an LEA to have an appropriate mental health professional provide brief interventions at a school campus, when necessary, for all referred students, including students with a health care service plan, health insurance, or coverage through a Medi-Cal MCP, but not those covered by a county mental health plan. This bill would also allow the behavioral health services provided by the LEA to be conducted via telehealth.	**02/17/2021** Introduced	CalOptima: Watch
SB 682 Rubio	**Childhood Chronic Health Conditions:** Would require the California Health and Human Services Agency, the Governor's office, and the Office of Health Equity to address and reduce racial disparities in children with chronic health conditions by 50% by 2030.	**02/19/2021** Introduced	CalOptima: Watch

*Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: March 10, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 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
April 1, 2021

CalOptima Community Outreach Summary — March 2021

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 and 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 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 participate 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 Event Update
Since July 2016, the Community Relations department has hosted Cafecito meetings, a collaborative designed to enhance relationships between CalOptima and key stakeholders serving the Latino community. The goal is to increase the community's knowledge and understanding of CalOptima, Medi-Cal programs and services, and community resources. Cafecito also provides community partners with opportunities to collaborate and share best practices to better serve the Latino community. As of 2021, Cafecito has nearly 50 community partners actively engaged in these bi-monthly meetings.

On Tuesday, March 2, 2021, Community Relations hosted a Cafecito meeting with Orange County Health Care Agency Director and County Health Officer, Dr. Clayton Chau who also serves on CalOptima's Board of Directors and CalOptima's Interim Medical Director, Dr. Emily Fonda as featured presenters. Presenters shared information on Orange County's COVID-19 vaccine plan and CalOptima's role in improving access to vaccinations for members living in communities hardest hit by the pandemic. Hope Builders, Regional Center of Orange County, Family Caregiver Resource Center, and representatives from Santa Ana Unified and Anaheim Elementary School Districts were some of the organizations in attendance.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities
CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

As of February 16, 2021, **through virtual meetings and teleconferences**, CalOptima expects to participate in 25 community events, coalition and committee meetings during March.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
3/2/2021	• Collaborative to Assist Motel Families Meeting
3/3/2021	• Anaheim Human Services Network Meeting
3/4/2021	• Continuum of Care Homeless Provider Forum • Garden Grove Community Collaborative Advisory Meeting
3/8/2021	• Orange County Veterans and Military Families Collaborative — Children and Family Working Group • Fullerton Collaborative Meeting
3/9/2021	• Orange County Cancer Coalition Meeting • Wellness and Prevention Coalition Meeting
3/10/2021	• Anaheim Homeless Collaborative Meeting
3/11/2021	• Buena Park Collaborative Meeting • Garden Grove Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting
3/12/2021	• Senior Citizens Advisory Council General Meeting
3/15/2021	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting • Spirituality Conference: 2020 Looking Back, Moving Forward hosted by Alzheimer's Family Center (Registration fee: $400 and $25 opportunity drawing included a virtual booth on all five days of the event)
3/16/2021	• North Orange County Senior Collaborative All Members Meeting • Placentia Community Collaborative Meeting • Aging and Disability Resource Connection Advisory Committee Meeting
3/17/2021	• Covered Orange County Steering Committee Meeting

Back to Agenda

	• Orange County Communications Workgroup • Minnie Street Family Resource Center Professional Roundtable
3/22/2021	• Stanton Collaborative Meeting
3/23/2021	• Clinic in the Park Collaborative Meeting
3/25/2021	• Orange County Care Coordination for Kids Collaborative Meeting

As of February 16, 2021, CalOptima expects to organize or convene nine community stakeholder events, meetings or presentations through **virtual meetings or teleconferences** during March.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	**Events/Meetings/Presentations**
3/2/2021	• Cafecito Meeting
3/3/2021	• Community-Based Organization Presentation for Mental Health Association — Topic: Medi-Cal in Orange County (English)
3/18/2021	• Health Network Forum
3/19/2021	• Community-Based Organization Presentation for 211 OC — Topic: Medi-Cal in Orange County (English)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	**Events/Meetings/Presentations**
3/8/2021	• Community-Based Organization Presentation for Orange Coast College Public Health — Topic: Medi-Cal in Orange County (English)
3/16/2021	• Community-Based Organization Presentation for Santa Ana Unified School District — Topic: Medi-Cal in Orange County (Spanish)
3/18/2021	• Community-Based Organization Presentation for Garden Grove Unified School District School Readiness Parents — Topic: Medi-Cal in Orange County (English)
3/23/021	• Community-Based Organization Presentation for Santa Ana Early Learning Initiative Parents — Topic: Medi-Cal in Orange County (Spanish)
3/24/2021	• Community-Based Organization Presentation for Benito Juarez Elementary Parents — Topic: Medi-Cal in Orange County (Spanish)

CalOptima provided two endorsements consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the

Back to Agenda

last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Letter of Support to the Multi-Ethnic Collaborative of Community Agencies (MECCA) for funding from the Robert Wood Johnson Foundation to launch OC Rise, which will focus on recovery, racial equity and improved health outcomes for people of color in the county. Services will include trauma-informed mental health services, case management and outreach to under-served survivors of trauma in Orange County.

2. Use of CalOptima's name or logo for the Orange County Business Council 2021–2022 Legislative Action Guide and Policy Platform.

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 opportunity to increase awareness of
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.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima has transitioned how we engage with our community partners and is not attending in-person community collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers were provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided the future event(s) meet the criteria set forth in Policy AA.1223 and meets eligibility requirements indicated by Board of Directors.

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.

CalOptima
A Public Agency
Better. Together.

April

Date and Time	Event Title	Event Type/Audience	Staff/Volunteer/ Financial Participation	Location
Thursday, 4/1 9–11 a.m.	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 4/1 11 a.m.–1 p.m.	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/6 9:30–11 a.m.	++ Collaborative to Assist Motel Families Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/7 10 a.m.–12 p.m.	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	2 Staff	Virtual format
Wednesday, 4/7 10 a.m.–12 p.m.	++ Anaheim Human Services Network Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/7 10:30 a.m.–12 p.m.	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 4/8 10:00–11:30 a.m.	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 4/8 11:30 a.m.–12:30 p.m.	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Thursday, 4/8 12:30–1:30 p.m.	++Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Friday, 4/9 9–11 a.m.	++Senior Citizens Advisory Council General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Monday, 4/12 1–2:30 p.m.	++Orange County Veterans and Military Families Collaborative - Children and Families Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

Monday, 4/12 2:30–3:30 p.m.	++Fullerton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/13 10–11:30 a.m.	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/13 10 a.m.-12 p.m.	++Orange County Health Access and Enrollment Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/13 3:30–5:30 p.m.	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/14 12–1:30 p.m.	++Anaheim Homeless Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/14 1:30–3:30 p.m.	++Health Care Task Force Meeting	Steering Committee Meeting: Open to Collaborative Members	2 Staff	Virtual format
Thursday, 4/15 9–11:00 a.m.	*Health Network Forum	Health and Human Service Providers	10+ Staff	Virtual format
Monday, 4/19 1–4 p.m.	++ OCHCA Mental Health Services Act Steering Committee Meeting	++ OCHCA Mental Health Services Act Steering Committee	1 Staff	Virtual format
Tuesday, 4/20 11 a.m.–12 p.m.	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/20 1-2:30 p.m.	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/21 9–10:30 a.m.	++ Covered Orange County Steering Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Wednesday, 4/21 11 a.m.–12 p.m.	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

Wednesday, 4/21 3:30–4:30 p.m.	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Conference call
Thursday, 4/22 1:30–3:30 p.m.	++ Orange County Care Coordination for Kids Meeting	Steering Committee Meeting: Open to Collaborative Members	2 Staff	Virtual format
Monday, 4/26 12:30–1:30 p.m.	++Stanton Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Tuesday, 4/27 9–10:30 a.m.	++Clinic in the Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format
Wednesday, 4/28 9–10:30 a.m.	*Cafecito Meeting	Steering Committee Meeting: Open to Collaborative Members	3 Staff	Virtual format
Wednesday, 4/28 3–4:30 p.m.	++Orange County Strategic Plan for Aging Leadership Council Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual format

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Contract with Medical Review Institute of America, LLC (MRIoA) for Clinical Medical Record Review Services and Reallocate Budgeted but Unspent Salary Dollars to Fund These Services; Ratify contract with MRIoA, effective March 1, 2021, through June 30, 2021, to support timely and compliant completion of authorization requests, appeals, peer reviews and special investigations; and Authorize reallocation of budgeted but unused funds of up to $120,000 from Medical Management – Salaries to Medical Management – Professional Fees to support services provided by MRIoA through June 30, 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, RN, CCM, Executive Director, Clinical Operations, (714) 246-8549

Recommended Actions

1. Ratify contract with Medical Review Institute of America, LLC (MRIoA), effective March 1, 2021, through June 30, 2021, to support timely and compliant completion of authorization requests, appeals, peer reviews and special investigations; and
2. Authorize reallocation of budgeted but unused funds of up to $120,000 from Medical Management – Salaries to Medical Management – Professional Fees to support services provided by MRIoA through June 30, 2021.

Background

The Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require CalOptima to ensure that qualified personnel and appropriate processes are used to review and approve the provision of medically necessary covered services for members. Important considerations include timely decision-making, notifications and the preservation of members' grievance and appeal rights.

The National Committee for Quality Assurance (NCQA) Utilization Management Standards require the use of board-certified physicians to assist in making medical necessity determinations. In the case of appeals, the review of an appeal must be conducted by a practitioner who is in the same or a similar specialty as the requestor.

Each month, CalOptima reviews nearly 1,000 requests for health care services that are of a complexity requiring review by a physician Medical Director. CalOptima Medical Directors share 24/7 call coverage and are also responsible for acting as a chairperson and/or participant in committee meetings, clinical programs, projects and quality improvement efforts. The COVID-19 public health emergency has further increased activities and initiatives requiring medical expertise and direction.

CalOptima currently has four board-certified Medical Directors on staff, with an additional three full-time Medical Director positions that are vacant. (One of the positions has been open since June 2018, one since January 2019, and the third is a recent vacancy.)

Back to Agenda

In order to meet its regulatory, accreditation, and contractual obligations, CalOptima has taken action to provide additional medical review capacity, including:

- On February 1, 2014, CalOptima contracted with Advanced Medical Reviews LLC to provide clinical medical record review services for CalOptima.

- On April 2, 2020, the Board of Directors (the Board) approved reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund contracts with medical consultants to assist with CalOptima's response to the pandemic.

- On April 16, 2020, the Board authorized amendments to contracts with medical consultants and authorized unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

- On December 3, 2020, the Board approved reallocation of budgeted but unused funds in the amount of $125,00 to expand the contract for external peer review services and to extend the contract for medical consulting services.

Discussion

CalOptima's Medical Directors are responsible for providing physician leadership and medical expertise across the agency. Their responsibilities are foundational to the operations of the following departments: Quality, Utilization Management, Case Management, Population Health Management, Pharmacy, Behavioral Health Integration, Program for All-Inclusive Care for the Elderly and Long-Term Care. In addition, they collaborate with support departments, such as Compliance, Information Services, Claims, Contracting and Provider Relations.

Through attrition, three Medical Director positions have become vacant over the past few years. Despite CalOptima's concerted efforts to recruit, these positions remain unfilled. CalOptima currently has three vacant Medical Director positions out of a total of 7.5 full-time equivalent positions. The remaining Medical Directors have taken on the additional workload to support CalOptima's mission and operations. However, the deficit in staff has severely impacted CalOptima's ability to maintain compliance with timely decision-making in several operational areas. In December 2020, CalOptima's Compliance department issued an Immediate Corrective Action (ICAR) finding for Grievance and Appeals timeliness. CalOptima self-reported the finding to CMS and DHCS, as required.

In response to the ICAR, CalOptima selected a vendor partner to serve as an adjunct to CalOptima's employed Medical Director staff, through the Board-approved bid exception process. CalOptima entered into a contract with MRIoA effective March 1, 2021. The contract is effective through June 30, 2021, with terms allowing for one-year extensions pending Board approval. Staff requests ratification of the MRIoA contract to allow continuation of peer review, addressing Grievance and Appeals as promptly as possible, and fulfilling CMS and DHCS timeliness requirements.

Back to Agenda

Fiscal Impact

The fiscal impact of the recommended action is budget neutral. Unspent budgeted funds from Medical Management – Salaries approved in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget on June 4, 2020, will fund the total cost of up to $120,000 for the recommended action.

Rationale for Recommendation

Staff recommends Board ratification of a contract with MRIoA to maintain compliance with regulatory and contractual standards.

Concurrence

Gary Crockett, Chief Counsel

Attachments

- Entities Covered by this Recommended Action
- Contract with Medical Review Institute of America, LLC.
- December 3, 2020 CalOptima Board Action Authorization of the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services; which includes the prior Board actions below:
    - April 16, 2020 CalOptima Board Action Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic
    - April 2, 2020 CalOptima Board Action Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez *03/24/2021*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Medical Review Institute of America, LLC	2875 South Decker Lake Drive, Ste. 300	Salt Lake City	UT	84119

Back to Agenda Back to Item

ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between **Orange County Health Authority**, a Public Agency, **dba CalOptima** ("CalOptima"), and **Medical Review Institute of America, LLC**, a Delaware limited liability company ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract:

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.3 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.4 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.5 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.5.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.5.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.6 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.7 "CalOptima Programs" means the Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.8 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.9 "CCS Providers" or "CCS-Paneled Providers(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.10 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.11 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.12 "Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.13 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

Back to Agenda Back to Item

1.14 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.15 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.16 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.17 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators."

1.18 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

1.19 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.20 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.21 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.22 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.23 "Medi-Cal" is the name of the Medicaid program for the State of California (*i.e.,* the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

1.24 "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

1.25 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.26 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

Back to Agenda Back to Item

1.27 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.28 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.29 "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.30 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.31 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.32 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.
PACE Services shall include the following:

a. All Medicare-covered items and services
b. All Medi-Cal covered items and services; and
c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.33 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.34 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.35 Whole Child Model Program" or "WCM", means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

1.36 Additional Definitions.

(a) Utilization Review Accreditation Commission ("URAC").

(b) National Committee for Quality Assurance ("NCQA").

(c) Health Information Trust Alliance ("HITRUST").

(d) Medical Doctor ("MD").

(e) Doctor of Osteopathic Medicine ("DO").

(f) "Allied Health Care Practitioners" means health care practitioners that are neither MDs or Dos, including, but not limited to chiropractors, nurses, physical therapists,

occupational therapists and speech therapists.

(g) "FER" mean Federal External Review.

(h) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(i) "TAT" means turnaround time (i.e., the period of time between when Provider receives a case for review from CalOptima and when Provider returns the case to CalOptima).

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or participation status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to Health Networks the same terms regarding Provider performance, duties and obligation and rates for Covered Services provided to CalOptima Members enrolled in Health Networks. Provider agrees to contract with a Health Network(s) upon the request of a Health Network(s).

2.12 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities and public reporting to consumers, as identified in CalOptima policy GG.1638.

2.13 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.14 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

Back to Agenda Back to Item

2.15 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

2.16 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, foster in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider.

2.17 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.18 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.19 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color,

religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and

Back to Agenda Back to Item

its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.20 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.21 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.22 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance

Back to Agenda Back to Item

with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.23 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.24 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.24.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.24.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.24.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.24.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients.

2.24.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.24.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

2.24.7 An agreement to comply with CalOptima's Compliance Program.

2.24.8 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.25 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of

Back to Agenda Back to Item

Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.26 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.26.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.26.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.26.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.26.4 Provider shall include the obligations of this Section in its Subcontracts.

2.26.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.27 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

2.28 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.29 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.30 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types

Back to Agenda Back to Item

of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.31 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.32 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.33 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the Provider shall follow CCS Program Guidelines, including CCS Program regulations, and where CCS Clinical guidelines do not exist, Provider will use evidence -based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.35 CCS Provider Compliance.

2.35.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.35.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.35.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.35.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.36 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.37 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.38 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best

Back to Agenda Back to Item

information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.39 Standard of Performance. Provider shall perform the services in accordance with the standards of care, diligence, skill and judgment normally and reasonably exercised by professional firms and individuals with respect to services of a similar nature. Provider is a URAC accredited Independent Review Organization. CalOptima agrees that Provider's services are solely advisory in nature. All decisions concerning the determination as to payment or denial of payment for any claim or any decision regarding the delivery, performance or any interaction with any patient or client of CalOptima shall be solely as determined by CalOptima, and Provider shall have no liability with respect to any such decision. CalOptima agrees that Provider is not serving as a "fiduciary" pursuant to any plan or arrangement of CalOptima pursuant to ERISA and is not responsible for compliance of any plan of CalOptima with ERISA or other regulation. Provider has no discretion or authority to make any decision for eligibility to receive benefits as relating to any CalOptima plan or benefit arrangement. The services will be performed in accordance with state and federal regulations, as applicable. Provider peer reviewers (each a "Peer Reviewer," collectively "Peer Reviewers") are credentialed and licensed MDs, DOs and Allied Health Care Practitioners. Notwithstanding anything to the contrary contained in this Contract, the parties hereby agree that the services shall in all cases be deemed an opinion offered by Provider (rather than any statement of fact) and solicited by CalOptima, and in no event shall any third party have any right to rely on the results of the services in any way.

2.40 The Parties understand and agree that CalOptima administers government health programs exclusively, and that no services subject to ERISA shall be referred to Provider under this Contract.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

3.3 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

ARTICLE 4
PAYMENT PROCEDURES

4.1 Billing and Claims Submission. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery

of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.7.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

4.7.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.7.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

Back to Agenda Back to Item

4.8.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.8.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Additionally, CalOptima does hereby release and shall defend, indemnify and hold Provider, its parent, subsidiaries and affiliated companies, along with their respective officers, directors, agents and employees harmless from all losses, liabilities, claims (including but not limited to those arising under federal, state or local laws), costs (including, but not limited to, attorney's fees, expert fees, document management fees and costs, and court costs), actions or damages of any sort whatsoever arising out of (i) any fiduciary or other claim pursuant to ERISA as related to the Services, and (ii) any failure by Client or any of its plans or arrangements to comply with ERISA. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.9 Limitation of Liability. Except with respect to the indemnification or confidentiality provisions contained herein, in no event shall either party be liable to the other party whether in contract, tort or otherwise for payment of any punitive, special, exemplary, indirect, incidental, consequential or similar damages, including, but not limited to, lost profits or loss of business, even if a party is apprised of the likelihood of such damages occurring.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

6.7 Use of Name. Each party shall retain ownership of any and all of its intellectual property rights (including, without limitation, any rights to patent, copyrights and trade secrets. Neither party, nor its employees, officers, or agents or any of its entities, by virtue of this Contract shall acquire any rights to use, and they shall not use the other party's name, trade name, trademark, logo or other intellectual property (either alone or in conjunction with or as part of any other work or name) in any advertising, publicity or promotion; to express or imply any endorsement of its work or services.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2021. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to

comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such

regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.9 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

Medical Review Institute of America, LLC
Name

Legal Department
Title

2875 South Decker Lake Drive, Suite 300
Address

Salt Lake City, UT 84119

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Provider covenants that, for the term of this Contract, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective March 01, 2021 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
Ron Sullivan	
Signature	Signature
Ron R. Sullivan	Ladan Khamseh
Print Name	Print Name
Chief Executive Officer	Chief Operating Officer
Title	Title
Mar 2, 2021	3/3/2021
Date	Date

Adam Schilling
Randy Iskowitz
Zach R. Harding

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Programs. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

__X__ Medi-Cal Program

__X__ Medicare Advantage Program (OneCare)

_____ PACE Program

__X__ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

ARTICLE 2
CLINICAL MEDICAL RECORD REVIEW- SCOPE OF WORK

2.1 Types of Services

2.1.1 Utilization Management Reviews

2.1.1.1 A board-certified physician performs a detailed review of a request for service and related medical records to determine if the request is a covered benefit and whether the service is medically necessary.

2.1.2 Appeals

2.1.2.1 A board-certified, same specialty physician provides an independent review, as requested by CalOptima, of a previously denied request for service, which has been appealed by the Member or a provider.

2.1.3 Coding and Fee Analysis as requested by CalOptima.

2.1.4 Special Investigations (SIU)/Fraud, Waste and Abuse (FWA) Reviews as requested by CalOptima, which may include Behavioral Health cases.

3.1 Provider's Responsibilities

3.1.1 Provider will maintain a panel of credentialed physician Peer Reviewers, with the following qualifications, and only those credentialed can review CalOptima cases:

3.1.1.1 Current, valid unrestricted California Physician & Surgeon License.

3.1.1.2 Board certification in area of specialty recognized by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists, or other licensure board recognized by the Utilization Review Accreditation Commission.

3.1.2 Provider will be available during CalOptima's normal business hours, excluding federal and state designated holidays, to receive inquiries and referrals by telephone, secure web portal or fax. Provider may be asked to respond to expedited requests on weekends or holidays.

3.1.3 Provider shall assign cases to a Peer Reviewer in accordance with NCQA guidelines or as required by CalOptima.

3.1.4 Provider will review and make decisions based upon regulatory requirements (Medicare Manual of Criteria, Medicare National Coverage Determinations and Local Coverage Determination guidelines, Medicare Part D: CMS-approved Compendia, California Title XXII, Federal and California Early and Periodic Screening, Diagnosis and Treatment Guidelines, California Children's Services Numbered Letters), and evidence-based criteria (e.g.: MCG, USPSTF, Specialty society guidelines, National Guideline Clearinghouse).

3.1.5 Provider will provide a decision for UM and appeals requests withing the following timeframes:

3.1.5.1 UM Standard review will be completed within forty-eight to seventy-two hours.

3.1.5.2 Appeals Standard review will be completed within forty-eight hours.

3.1.5.3 Expedited review be completed as soon as possible, but not to exceed twenty-four (24) hours.

3.1.6 Provider's decision for UM and appeal request will include the following:
- 3.1.6.1 Reason for referral, including the question/issue CalOptima has submitted for review.
- 3.1.6.2 Clinical summary, including a brief discussion of the beneficiary's clinical course.
- 3.1.6.3 Review data, documenting the information that the Peer Reviewer utilized in rendering his/her recommendation/decision.
- 3.1.6.4 Recommendation/decision, including specific answers to CalOptima's question(s).
- 3.1.6.5 Rationale, including a clear, succinct discussion supporting the Peer Reviewer's recommendation/decision.
- 3.1.6.6 Conflict of interest Statement.
- 3.1.6.7 Name, board certification and state licensure of Peer Reviewer completing the report, including expiration dates of license(s)/certification(s).

4.1 Litigation Support. In the event of a federal or state investigation or legal proceedings against CalOptima (including any subpoena) arising as a result of an official and final review decision by Provider, Provider shall, upon CalOptima's request, use commercially reasonable efforts to support the external review decision provided pursuant to this Contract at CalOptima's expense. In the event that CalOptima engages Provider or any Provider independent contractor or other Provider personnel to act as a fact witness or consultant or to respond to a subpoena for information in regard to a review performed by Provider under this Contract or if any Provider personnel are required to appear in any way as part of an investigation, CalOptima agrees to pay Provider for such services according to Provider's Legal Services Fee Schedule that will be provided at the time such services are requested or required. If any Provider personnel or Provider independent contractor is not willing or able to act as a witness or consultant to CalOptima for any reason, Provider shall use commercially reasonable efforts to provide another comparably skilled witness or consultant or independent contractor to provide support to CalOptima pursuant to this Section.

ARTICLE 3
CLINICAL MEDICAL RECORD REVIEW
REVIEW SERVICES WORKFLOW

1. **Review Services Workflow.**
   a. Case Initiation.
      i. All case referrals and records shall be submitted by CalOptima online through Provider's secure web portal.
      ii. CalOptima must obtain and submit to Provider all relevant medical records and other relevant documents initially at the time of original submission of the review in conjunction with the review submittal form through Provider's secure web portal.
      iii. Any additional review requests, changes to the original review request or additional documentation submitted will restart the turnaround time period.
      iv. Any addendum regarding any question(s) or additional information that was not presented/raised by CalOptima at the time of the initial referral if the initial referral has been completed will require re-submission for additional review and shall result in an additional charge.
      v. Provider shall provide any material related to the review that Provider receives from any individuals, providers or other entities that submit such material (not including verbal information) online through Provider's secure web portal.
      vi. CalOptima shall send only copies of the medical records and other documents, not originals. Non-paper and/or non-electronic review material submitted for case review such as, x-rays or dental molds, etc., may be sent non-paper form and shall be returned to the CalOptima upon completion of the case review at CalOptima's expense.
   b. Peer Reviewer Panel and Case Assignment.
      i. Provider maintains a panel of credentialed Peer Reviewers. Provider shall assign cases to Peer Reviewer(s) in accordance with applicable law, Provider policies and procedures and in accordance with applicable accreditation standards.

ii. Provider Peer Reviewers shall comply with Provider's corporate confidentiality policies and procedures in compliance with applicable accreditation standards, HIPAA privacy and security rules, and applicable state laws.

c. Communication Standards.

i. Provider, where required by law, legal process or contract, shall use commercially reasonable efforts to communicate with the attending provider or designee while the case is open and within the required turnaround time frame unless the attending provider is unavailable.

ii. Provider shall deliver its case review report/submittal form to CalOptima via its secure web portal, unless otherwise requested by CalOptima and agreed to by Provider. Provider is not responsible for issuing notification to the member or authorized representative, attending physician, or other ordering provider or facility rendering service.

iii. Peer Reviewers shall not discuss specific case reviews with CalOptima at any stage of the review process, except when Provider agrees that such discussion is appropriate within the scope of the review process and/or upon special, case-specific arrangement agreed to by and between CalOptima and Provider.

2. **Reporting**. Provider provides reporting regarding the performance of its delegated responsibilities online via its Client Tools web portal. CalOptima may customize reports via the web portal to include any information relevant to CalOptima and schedule the frequency in which the reports will be automatically generated. Provider may provide additional ad-hoc reports upon request in a format agreed to by both Parties.

3. **Oversight and Audits**. Provider will cooperate with CalOptima's efforts to implement quality improvement and other activities. CalOptima may conduct audits/surveys of Provider to evaluate Provider's compliance with regard to this Section but no more than once per year unless a material non-compliance with the terms of this Contract has been found in a prior audit. Additionally, Provider must have agreed to the schedule, time and manner of such audits/surveys and such audits/surveys must not interfere with Provider operations. Provider will cooperate with CalOptima to address and correct any identified issues.

4. **Delegation**. Provider shall obtain the express written consent of CalOptima prior to delegating any organizational functions (not including Clinical Medical Record Reviews) under the Contract to a third party. If CalOptima provides written consent to such a delegation of organizational functions to a third party, the third party shall be subject to the terms of the Contract and applicable accreditation standards in performance of the delegated organizational functions. Provider will notify CalOptima of any material change in Provider's ability to perform delegated functions.

5. **Accessibility**. Provider shall maintain telephonic and fax access, and a secure web portal to receive CalOptima inquiries and/or referrals. Provider's normal business hours are 7:00 a.m. to 5:00 p.m. Mountain Time ("MT"), Monday through Friday, excluding Provider-designated holidays (such days, "Business Days" and references in this Contract to "days" shall mean calendar days unless Business Days are referenced). Provider shall also maintain access to service outside of normal business hours, Monday through Friday including designated holidays and weekends.

6. **Business Hours/Days TAT.**
"Same Day Business TAT" is defined as a case that is received by Provider by 10:00 a.m. MT on a Business Day and will be returned to CalOptima by 6:00 p.m. MT that same day or 8 business hours later according to Provider's normal business hours (Monday-Friday, 7:00 a.m. to 5:00 p.m. MT) if the case is received by Provider after 10:00 a.m. MT, and to be returned to CalOptima the next business day.

- *Example 1*: Provider receives a case from CalOptima at 2:00 p.m. MT on a Friday, then Provider will return the case to CalOptima by noon MT the following Monday.
- *Example 2*: Provider receives a case on a Tuesday at 4:00 p.m. MT, then Provider will return the case to CalOptima by 2:00 p.m. MT the next day (Wednesday).

"24-Hour Business TAT" is defined as a case that is received by Provider during Provider's normal business hours (Monday-Friday, 7:00 a.m. to 5:00 p.m. MT) and will be returned to CalOptima by the next Business Day at the same time it was received the previous day.

- *Example 1*: Provider receives a case at 11:00 a.m. MT on a Friday, then Provider will return the case to CalOptima by 11:00 a.m. MT the following Monday.
- *Example 2*: Provider receives a case on a Wednesday at 3:00 p.m. MT, then Provider will return the case to CalOptima by 3:00 p.m. MT the next day (Thursday).

"48-Hour Business TAT" is defined as a case that is received by Provider during normal business hours (Monday-Friday, 7:00 a.m. to 5:00 p.m. MT) and will be returned to Client by the 2nd Business Day at the same time it was received two days before.

- *Example 1*: Provider receives a case at 11:00 a.m. MT on a Friday, then Provider will return the case to CalOptima by 11:00 a.m. MT the following Tuesday.
- *Example 2*: Provider receives a case on a Wednesday at 3:00 p.m. MT, then Provider will return the case to CalOptima by 3:00 p.m. MT on Friday.

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

CLINICAL MEDICAL RECORD REVIEW

1. **Health Utilization Management – Initials**

   Flat Rate: [redacted]

   Additional Costs:
   - 24-Hour
   - Same Day
   - Weekend/Holiday*

   [redacted]

   Assumptions:
   - Cases to be completed with the requested TAT
   - Initials to have one (1) criteria-based question
   - For cases with >50 pages of medical records and/or >1 criteria-based question, specialty match appeals pricing below applies
   - If specialty match is required, flat rate is [redacted] per case (all other assumptions remain the same)
   - For specialty match cases with >50 pages and/or >1 criteria-based question, specialty match appeals pricing applies
   - Reviews to be completed by board-certified physicians licensed in the appropriate state and specialty

2. **Health – Specialty Match Appeals**

   Flat Rate: [redacted] per case

   Hourly Rate: [redacted] per hour (billed in 15-minute increments with a minimum charge of 1 hour)

   Additional Costs:
   - 24-Hour
   - Same Day
   - Weekend/Holiday*

   [redacted]

   Assumptions:
   - Cases to be completed with the requested TAT
   - Flat Rate applies to all cases with up to 75 pages of medical records and up to 3 questions
   - Hourly Rate applies to all cases with >75 pages of medical records and/or cases with >3 questions
   - Hourly Rate applies to any case requiring a peer-to-peer call
   - Reviews to be completed by board-certified physicians licensed in the appropriate state and specialty

3. **Health – SIU/Fraud/QI**

   Hourly Rate: [redacted] per hour (billed in 15-minute increments with a minimum charge of 1 hour)

Additional Costs:

- 24-Hour
- Same Day
- Weekend/Holiday*

Assumptions:

- Cases to be completed with the requested TAT
- Reviews to be completed by board-certified physicians licensed in the appropriate state and specialty

*Holidays shall be New Year's Day, Martin Luther King Jr. Day, Presidents Day, Memorial Day, Independence Day (Observed), Labor Day, Veteran's Day, Thanksgiving Day, Friday after Thanksgiving, Christmas Day (Observed), New Year's Day (Observed)

PAYMENT PROCEDURES

4. **Clinical Medical Record Review**

4.1 Provider shall submit all billings to the following address, as appropriate:

CalOptima-Accounts Payable
505 City Parkway West
Orange, Ca 92868
Alternatively, Provider may email invoices to AccountsPayable@caloptima.org

4.2 CalOptima agrees to make a payment withing thirty (30) business days from receipt of an invoice Services provided by Provider under this contract.

ATTACHMENT D

DISCLOSURE FORM

Medical Review Institute of America, LLC
Name of Provider

The undersigned hereby certifies that the following information regarding Medical Review Institute of America, LLC (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
Ron Sullivan (CEO), David Baugh (CFO), Randy Iskowitz (CRO), Gerald Denny (CMO), Donald Murphy (CIO), Aja Leichliter (Sr. Director/CCO), Bob O'Brien (Executive, Best Care), William W. Low, III (President)

Co-Owner(s):
Summit Partners Growth Equity
MRIoA Founders Holdco.

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
Not applicable.

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
Not applicable.

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
Limited Liability Company formed under the laws of Delaware.

Dated: Mar 2, 2021

Signature: Ron Sullivan

Name: Ron R. Sullivan
(Please type or print)

Title: Chief Executive Officer
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

   Provider shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3 Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States

Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

7. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

8. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

9. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through the DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, or agents as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, or agents shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

    Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

    11.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

    11.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

    11.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

12.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

12.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

12.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

12.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

12.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

12.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

12.1.6 Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

12.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

12.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

12.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

13. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

14. Lobbying Restrictions and Disclosure Certification.

14.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.2 Certification and Disclosure Requirements

14.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 14.3 of this provision.

14.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using

nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 14.3 of this provision if paid for with appropriated funds.

14.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

14.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements.

15.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

15.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed

in accordance with all laws and applicable regulations governing the DHCS Contract.

15.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.23 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

15.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 16 of this Addendum 1.

15.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.7 of the Contract.

15.2.10 An agreement to notify DHCS in the manner provided in Section 7.9 of the Contract in the event the Subcontract is amended or terminated.

15.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.17 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.16 or the Contract.

15.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

15.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5. of the Contract.

15.2.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

15.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

16. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

18 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from

management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Medical Review Institute of America, LLC	Ron R. Sullivan
Name of Contractor	Printed Name of Person Signing for Contractor
	Ron Sullivan
Contract / Grant Number	Signature of Person Signing for Contractor
Mar 2, 2021	Chief Executive Officer
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 1 – Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D C 20503.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Provider agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, DHHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

   (b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

   (c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set forth in this Contract. Moreover, CalOptima shall have the right to require Provider to

terminate any Subcontracting provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review and approve Provider's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Provider agrees to comply with MSP requirements. Provider shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Provider Authority to Bill Third Party Payers. Provider may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Provider Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Provider may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Provider agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Provider bills a third party payor as primary. Provider agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Provider, or, CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Medical Review Institute of America, LLC	Ron R. Sullivan
Name of Contractor	Printed Name of Person Signing for Contractor
	Ron Sullivan
Contract / Grant Number	Signature of Person Signing for Contractor
Mar 2, 2021	Chief Executive Officer
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 2 – Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ADDENDUM 3

PACE PROGRAM REQUIREMENTS

Not Applicable to this Contract

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

Addendum 3 – Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

ADDENDUM 4
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Provider shall provide services or perform other activity pursuant to this Contract in accordance with (i) applicable DHCS and CMS laws, regulations, instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS.
2. Provider shall (i) safeguard Member privacy and confidentiality of Member health records (ii) comply with all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Provider and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Provider shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural and ethnic backgrounds. Provider shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6^{th}) grade reading level.
7. Provider shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
8. Provider shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of Provider. Provider may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Provider is compensated by the Contractor for services provided to the Member. CalOptima will not refuse to contract or pay Provider for the provision of covered services under the CalOptima Cal MediConnect Program solely because Provider has in good faith communicated or advocated on behalf of a Member as set forth above.
9. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to

suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above, CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Provider shall be responsible for any resulting overpayments.

10. Downstream Entity Contracts.

10.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414. Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

10.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 4 and Section 2.20 of the Contract.

10.1.2 An agreement to (i) Member financial protections in accordance with Section 4.7 of the Contract, including prohibiting Downstream Entities from holding an Member liable for payment of any fees that are the obligation of the Provider, and (ii) safeguard Member privacy and confidentiality of Member health records.

10.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 11 of this Addendum 4 and the reporting requirements of Section 5 of this Addendum 4.

10.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 12 of this Addendum 4 and 2.14 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 4.

10.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 13 of this Addendum 4.

10.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 14 of this Addendum 4.

10.1.7 Language that specifies the First Tier, Downstream and Related Entities must comply with the federal and state laws, regulations and CMS instructions.

10.1.8 Notify DHCS in the even the agreement with the subcontract is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

10.2 In addition to Section 10.1 of this Addendum 4, Provider shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

10.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Provider.

10.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

10.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 6 of this Addendum 4.

10.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 4.

10.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.7.1 of the Contract and Section 19 of this Addendum.

10.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 8 of this Addendum 4, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 16 of this Addendum 4.

10.2.7 An agreement that the medical provider assist the Provider and/or CalOptima in the transfer of care of a Member in accordance with Section 15 of this Addendum.

10.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 4, and (ii) to notify DHCS in the manner set forth in Section 7.9 of the Contract in the event the subcontract is amended or terminated.

10.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 18 of Addendum 4, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under the Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Provider and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

10.2.10 An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites in accordance with Section 2.17 of the Contract.

11. Right of Inspection, Evaluation, and Audit of Records. Provider and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

12. Provider and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.12 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Provider and/or its Downstream Entities have not performed satisfactorily.

13. Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review, approve, and audit Provider's credentialing process on ongoing basis.

14. Provider Terminations. In the event a provider is terminated for cause by Professional, Provider shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Provider terminates a provider for deficiencies in the quality of care provided, Provider shall give notice of the action to the appropriate licensing and disciplinary agencies.

15. In addition to Section 2.15 of the Contract, Provider agrees to assist CalOptima in the transfer of care of a Member. Provider shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

16. Provider is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

17. Assignment or Delegation. Provider agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Provider or Downstream Entity; (iii) the merger, reorganization, or consolidation of Provider or Downstream Entity, with another entity with respect to which Provider or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Provider or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Provider or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Provider agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Provider's or its Subcontractor's possession.

19. In addition to Section 4.7.1 of the Contract, Provider acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Medical Review Institute of America, LLC	Ron R. Sullivan
Name of Contractor	Printed Name of Person Signing for Contractor
	Ron Sullivan
Contract / Grant Number	Signature of Person Signing for Contractor
Mar 2, 2021	Chief Executive Officer
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Authorization of the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

Contacts

David Ramirez, M.D., Chief Medical Officer, Medical Management, (714) 347-3261
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574
Esther Okajima, Director, Quality Improvement, (714)347-3270

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Advanced Medical Reviews (AMR) to expand the scope of work to include the provision of the following services:
    a. Retro claims review to ensure medical services are billed appropriately;
    b. Review of Grievance and Appeal cases to ensure same or similar specialty review;
    c. Review of Behavioral Health cases; and
    d. Review of Fraud, Waste and Abuse cases.
2. Authorize reallocation of budgeted but unused funds to support the expanded scope of services for AMR through June 30, 2021:
    a. Up to $28,000 from Medical Management – Salaries to Medical Management – Professional Fees; and
    b. Up to $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees; and
3. Authorize reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees and to extend the contract with medical consultant, Peter Scheid, M.D., to assist with Potential Quality Issue (PQI) cases through June 30, 2021.

Background

CalOptima is required to review appeals and potential quality issues in order to maintain compliance with existing regulations and contractual obligations. Additionally, CalOptima must complete reviews within required timeframes in order to maintain compliance. Each month, CalOptima completes on average 140 appeal reviews and 134 PQI reviews. CalOptima currently has a staff of 6 board certified Medical Directors and two Medical Director positions that have been open since June 2018 and January 2019, respectively. CalOptima Medical Directors share 24/7 call coverage and also assist with committee meetings, clinical programs and projects, and quality improvement efforts.

Back to Agenda Back to Item

Since 2012, with CalOptima's pursuit of accreditation, use of board-certified consultants to assist in making medical necessity determinations is a requirement per National Committee for Quality Assurance (NCQA) Utilization Management (UM) Standards. Also, in the case of appeals, the review of an appeal must be conducted with a practitioner who is in the same or similar specialty. Per these standards, CalOptima must have policies and procedures for how board-certified consultants are used and provide evidence of how they are used as part of the decision-making process for denials and appeals.

On February 1, 2014, CalOptima entered into a contract with Advanced Medical Reviews (AMR). Currently, AMR is the only outside entity that provides clinical medical record review services for CalOptima.

With regard to hiring medical consultants, on April 2, 2020, the Board of Directors (the Board) approved reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants to assist with CalOptima's response to the Coronavirus (COVID-19) pandemic (refer to Attachment 1). On April 16, 2020, the Board authorized amendments to contracts with medical consultants and authorized unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020 (refer to Attachment 2). In order to maintain compliance with the required reviews of appeals and PQIs, staff is requesting reallocation of funding from the open Medical Director positions to support continued use of the temporary consultant.

Discussion

External Peer Review

There are many benefits for using External Peer Reviews (EPRs) for clinical medical record review. It can address conflicts of interest by removing bias and assists with regulatory, credentialing and accreditation requirements. Independent review services can also remove barriers for quality improvement efforts, ensure adherence to quality standards and reduce liability risk. Circumstances where a health plan would seek external peer review include, but are not limited to:

1. Litigation;
2. Conflicting recommendations from internal reviewers;
3. Lack of internal resources and expertise;
4. Review by same or similar specialty; and
5. Improving efficiency

Multiple CalOptima departments have business demands that require timely access to independent review services. Currently, Medical Directors leverage EPRs for the review of Potential Quality Issue (PQI) cases when the physician under review is of a specialty outside of the Medical Directors. CalOptima's current Medical Directors are board certified in Family Medicine, Internal Medicine, Psychiatry, Pediatrics and Cardiothoracic Surgery. Cases outside of these specialties are referred for independent review services. UM Medical Directors utilize EPRs to review denial cases as needed. Grievance and Appeals leverage independent review services to review second level appeals, especially when a reviewer with same or similar specialty is required. Claims utilizes EPRs for coding

validation of billed services. For Behavioral Health, only a qualified licensed clinical psychologist or board-certified psychiatrist can review and issue denials for medical necessity or benefit coverage. Access to EPRs with behavioral health specialty is essential in meeting regulatory requirements. Compliance utilizes EPRs to assist with reviewing medical records for potential Fraud, Waste and Abuse (FWA) cases. An effective Compliance Program requires timely investigation to ensure CalOptima can seek overpayment recovery or implement necessary preventive controls.

Management proposes to make a reallocation of budgeted but unused funds of $80,000 from Medical Management – Salaries. Several Medical Management vacant positions remain vacant, thereby making these funds available for reallocation.

- Reallocation of $28,000 from Medical Management – Salaries to Medical Management – Professional Fees: The CalOptima Fiscal Year (FY) 2020-21 Operating Budget includes $80,000 for external peer review services. With an expanded scope of services for AMR, staff projects a budget shortfall of $28,000 through June 30, 2021.

- Reallocation of $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees. The forecasted budget shortfall is based on current retroactive claims review utilization with a 10% increase to allow for any unexpected increase in utilization (see Attachment 3 for more details)

Medical Consultant

CalOptima's Medical Management Department requires additional resources in clinical reviews to reduce the workload for the current Medical Directors, especially in PQI cases. Unfortunately, CalOptima staff have been encountering challenges with hiring new Medical Directors. While continuing the efforts to recruit new Medical Directors, in the interim, CalOptima staff recommends extending a contract with the medical consultant, Dr. Peter Scheid, who is familiar with CalOptima's quality standards and internal processes, to provide additional clinical support to ensure our members' quality of care during this difficult time.

Management proposes to make a reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees to fund the contract through June 30, 2021.

Fiscal Impact

The fiscal impact for the recommended actions is budget neutral. Unspent budgeted funds from Medical Management – Salaries approved in the CalOptima Fiscal Year 2020-21 Operating Budget on June 4, 2020, will fund the total cost of $125,000 for the recommended actions.

Rationale for Recommendation

Staff is recommending Board approval to reallocate funds to meet changing business needs and expand options for external peer review to ensure optimal efficiency and timeliness in the clinical medical record review process. Staff also believes that extending the contract with the medical consultant will help reviewing PQI cases and other clinical decisions in a timely manner while maintaining high quality standards.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated April 2, 2020, "Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities"
3. Previous Board Action Dated April 16, 2020, "Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic"
4. AMR Consultants Usage Log

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Advanced Medical Reviews	PO Box 492345	Redding	CA	96049
Peter J. Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

Back to Agenda Back to Item

Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

Back to Agenda Back to Item

Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

Back to Agenda Back to Item

D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
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Back to Agenda Back to Item

TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

Back to Agenda Back to Item

Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*
Authorized Signature — **Date**

Back to Agenda Back to Item

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

Back to Agenda Back to Item

Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

Back to Agenda Back to Item

Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

Back to Agenda Back to Item

D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
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(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL COM
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Back to Agenda Back to Item

TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

AMR Consultants	FY19-20	FY20-21	14 mo RR	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Claims	$ 53,781	$ 5,319	$ 4,221		$ 1,379	$ 3,152	$ 4,531	$ 2,758	$ 6,501	$ 5,319	$ 5,319	$ 7,683	$ 5,713	$ 7,683	$ 3,743	$ 1,182	$ 4,137										
FWA	$ 8,393	$ 1,169	$ 683									$ 3,087	$ 775	$ 3,546	$ 985	$ 197	$ 972										
GARS	$ 54,372	$ 20,685	$ 5,361	$ 3,940	$ 2,561	$ 4,728	$ 6,304	$ 2,955	$ 7,880	$ 1,970	$ 6,698	$ 3,349	$ 5,122		$ 8,865	$ 9,850	$ 10,835										
Pharmacy	$ 1,773	$ -	$ 127	$ 197						$ 197		$ 197	$ 197		$ 985												
PQI	$ 7,513	$ 1,182	$ 621	$ 394	$ 486	$ 381	$ 1,773	$ 1,366	$ 486	$ 788	$ 1,445	$ 197			$ 197	$ 394	$ 788										
UM	$ 16,115	$ 5,132	$ 1,518	$ 92	$ 394	$ 197	$ 985	$ 985	$ 3,349	$ 3,546	$ 473	$ 1,366	$ 1,576	$ 1,379	$ 1,773	$ 3,047	$ 2,085										
Total	**$ 141,947**	**$ 33,487**	$ 12,531	**$ 4,623**	**$ 4,820**	**$ 8,458**	**$ 13,593**	**$ 8,064**	**$ 18,216**	**$ 11,820**	**$ 13,935**	**$ 15,879**	**$ 13,383**	**$ 12,608**	**$ 16,548**	**$ 14,670**	**$ 18,817**										

Medical Consultant Services	FY19-20	FY20-21	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Tanya Dansky, MD	$ 10,500	$ -										$ 5,250	$ 5,250													
Peter Scheid, MD	$ 20,700	$ 10,050									$ 4,200	$ 4,200	$ 4,800	$ 7,500	$ 4,950	$ 5,100										
Total	**$ 31,200**	**$ 10,050**									**$ 4,200**	**$ 9,450**	**$ 10,050**	**$ 7,500**	**$ 4,950**	**$ 5,100**										

Budget	**Monthly Est'**
818-020 Budget	$ 6,667
Medical Directory Salary .5 FTE	$ 9,265
Total	$ 15,931
Run Rate 2020 CY	**Monthly Est'**
AMR with Claims/GARS	$ 14,708
AMR with GARS, no Claims	$ 9,610
AMR without Claims/GARS	$ 3,774
Medical Consultant 10hr/Wk*$300/hr	$ 13,500

Existing Budget 818-020	80000
Run Rate * 10 months	125310
July/August invoice	34000
Claims Fund Request	52000
Amt needed in 818-020	27310

Row Labels	Count of Referring Dept
2019	**436**
Claims	106
GARS	216
Pharmacy	5
PQI	62
UM	47
2020	**480**
Claims	195
FWA	31
GARS	168
Pharmacy	8
PQI	16
UM	62
Grand Total	**916**

Row Labels	Count of Refer	Sum of Amount Billed
2019	**421**	**$ 64,669.00**
Claims	106	$ 20,882.00
GARS	213	$ 31,126.00
Pharmacy	5	$ 394.00
PQI	56	$ 5,477.00
UM	41	$ 6,790.00
2020	**487**	**$ 93,524.00**
Claims	195	$ 38,415.00
FWA	31	$ 4,847.00
GARS	173	$ 34,081.00
Pharmacy	8	$ 1,576.00
PQI	16	$ 2,627.00
UM	64	$ 11,978.00
Grand Total	**908**	**$ 158,193.00**

Back to Agenda

Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Approval of CalOptima's 2021–22 Legislative Priorities and 2021–22 Legislative Platform; Adopt CalOptima's 2021–22 Legislative Priorities; Adopt CalOptima's 2021–22 Legislative Platform; and Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the 2021–22 Legislative Priorities and Legislative Platform and provide regular progress reports to the Board of Directors

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Adopt CalOptima's 2021–22 Legislative Priorities;
2. Adopt CalOptima's 2021–22 Legislative Platform; and
3. Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the 2021–22 Legislative Priorities and Legislative Platform and provide regular progress reports to the Board of Directors.

Background

As part of its Government Affairs program, CalOptima staff track and analyze state and federal legislation that may impact CalOptima and its members, providers and other stakeholders. Staff also engage with federal and state trade associations, federal and state advocates, and elected officials at all levels of government to educate them on how proposed legislation and regulatory guidance may impact CalOptima.

To guide legislative advocacy efforts by staff and better represent CalOptima's interests in Sacramento and Washington, D.C., staff developed a 2021–22 Legislative Platform (Platform) for consideration by the CalOptima Board of Directors. When drafting the Platform, staff solicited input from CalOptima leadership to ensure public policy objectives reflect current organizational goals, including the 2020–2022 Strategic Plan. In determining whether a policy objective should be included within the Platform, staff considered whether it was: 1) likely to require or be impacted by legislative action; and 2) likely to be considered by Congress and/or the Legislature in the upcoming legislative sessions.

Discussion

Staff efforts and feedback identified the following policy priority areas for inclusion in the Platform:

- Response to COVID-19
- California Advancing and Innovating Medi-Cal (CalAIM)
    - Enhanced Care Management and In Lieu of Services
    - Dual Eligible Special Needs Plan
    - Population Health Management
    - Full Integration

Back to Agenda

- Social Determinants of Health (SDOH)
- Telehealth
- Youth Services
- Older Adult Services
- Medi-Cal Managed Care: Operations and Administration

The Platform includes multiple specific policy statements for each priority area. A high-level overview of the Platform's priority areas and policy statements is presented in a 2021–22 Legislative Priorities (Priorities) handout.

Pending Board approval is the adoption of the Priorities and Platform as well as authorization for the CEO, or designee, to implement federal and state legislative advocacy efforts that support the policy statements in the Platform. Such actions may include executing letters of support and opposition to lawmakers and other government officials on behalf of CalOptima, as well as authorizing formal CalOptima positions on introduced legislation. Any recommendation for a formal CalOptima position on introduced legislation will be brought to the Board for consideration.

Fiscal Impact
The recommended actions to adopt CalOptima's 2021–22 Legislative Priorities and 2021–22 Legislative Platform and authorize associated legislative advocacy efforts are operational in nature. Staff will include any expenses related to this action in the CalOptima Fiscal Year (FY) 2021–22 and FY 2022-23 Operating Budgets.

Rationale for Recommendation
Legislative advocacy continues to be a priority for CalOptima given the level of activity on health care-related issues in Congress and the State Legislature. Proactive engagement with trade associations, advocates and elected officials is critical to influencing policy decisions that are likely to impact CalOptima. Staff anticipate that several important issues, including COVID-19 vaccine administration, CalAIM implementation, telehealth expansion and addressing SDOH will require attention and involvement in the coming two years. Adoption of the 2021–22 Legislative Priorities and 2021–22 Legislative Platform will enable staff to be more strategic, focused and effective in their advocacy efforts regarding CalOptima's priority areas.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. 2021–22 Legislative Priorities
2. 2021–22 Legislative Platform

/s/ Richard Sanchez *03/24/2021*
Authorized Signature **Date**

Back to Agenda

2021–22 CalOptima Legislative Priorities

About CalOptima

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

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

Legislative Priorities

Response to COVID-19
The COVID-19 pandemic has significant health and financial impacts on CalOptima members, providers, health networks and stakeholders. CalOptima members are medically and financially vulnerable, and they overwhelmingly reside in communities that have been hardest hit by the pandemic. As of January 2021, approximately 8,000 CalOptima members have tested positive for COVID-19, 3,400 members have been hospitalized, and nearly 450 members have died. In addition to having an impact on members' physical health, COVID-19 has impacted their mental health as well. It is anticipated that there will be an ongoing increase in behavioral health-related services as a result of the pandemic. CalOptima will continue to play a vital role in closing this health equity gap by ensuring timely, no-cost access to testing, treatment and vaccination for members. Likewise, CalOptima's contracted providers and health networks are critical partners in delivering these services to CalOptima members.

Legislative Action: Support legislation that advances care, treatment and services related to the COVID-19 public health emergency.

California Advancing and Innovating Medi-Cal (CalAIM)
On January 8, 2021, DHCS released its formal proposal for CalAIM, a multiyear initiative to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms. While the COVID-19 pandemic delayed the 2020 CalAIM proposal, Governor Newsom's Proposed State Budget includes $1.1 billion for Fiscal Year (FY) 2021–22 and $1.5 billion for FY 2022–23 to implement CalAIM.

Legislative Action: Support legislation and regulatory policies and proposals for CalAIM initiatives that benefit CalOptima's members relating to Enhanced Care Management, In Lieu of Services, Dual Eligible Special Needs Plan, Population Health Management, and Full Integration.

Social Determinants of Health
Social determinants of health (SDOH) are social, economic and environmental factors that impact an individual's health and well-being. These factors include but are not limited to hunger, childcare, housing, employment and family life. According to CalOptima's 2018 Member Health Needs Assessment Final Report, SDOH can either facilitate good health or act as barriers. CalOptima members have identified financial stressors, social isolation and safety concerns as significant factors affecting their health. Additional, CalOptima members experiencing homelessness have unique challenges accessing the traditional health care delivery system. In 2019, Orange County's Point in Time Count reported nearly 7,000 individuals experiencing homelessness. In response to these findings, CalOptima has taken steps to strengthen the safety net for members by expanding access to primary care services and releasing community grants to support programs addressing the SDOH of our members.

Legislative Action: Support Medi-Cal funding for medical and non-medical services that address SDOH including but not limited to, food insecurity, nutrition, homeless health care initiatives, as well as housing and infrastructure.

Telehealth

On March 16, 2020, in response to the COVID-19 pandemic, the Department of Health Care Services (DHCS) expanded access to telehealth services to ensure providers can deliver medically necessary health care services in a timely fashion for beneficiaries. Temporary flexibilities, such as virtual assessments and audio-only telehealth calls, have contributed to an increase in access to providers and use of telehealth services. As a result, the number of CalOptima members who used telehealth services increased by 56,000 percent. Members and providers have expressed, making such flexibilities permanent would support the future of the health care delivery system as well as increase access for CalOptima's members.

Legislative Action: Support federal and state legislation and/or regulatory policies that expand access to telehealth services post the COVID-19 pandemic. This also includes advocating for the clarification of the difference in cost of care for delivering in-person services and telehealth services.

Youth Services

CalOptima's youth members are eligible to receive routine preventive care services, such as well-child visits; dental, vision and hearing care; behavioral health care and trauma screenings; and vaccinations. As of December 2020, there are approximately 310,000 CalOptima members who are under the age of 19. This includes 12,000 children with certain health conditions who receive care through the Whole Child Model program. CalOptima remains dedicated to providing coordinated, person-centered care for its youngest members.

Legislative Action: Support legislation that increases access to and the quality of care for CalOptima's youth members as it relates to Adverse Childhood Experiences (ACEs), the Whole Child Model program, and support for members living with a developmental disability.

Older Adult Services

As of December 2020, CalOptima has nearly 96,000 members age 65 and older. CalOptima and its community partners provide person-centered care to older adults in need of complex care. This includes providing greater access to skilled care, increasing awareness for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) Center, and by facilitating transitions from a medical setting to a home-based setting. Implementing a person-centered care system may include the coordination of physical health, oral health, mental health, cognitive health, and Long-Term Services and Supports (LTSS), in addition to promoting full access and health equity.

Legislative Action: Support legislation and regulatory policies that increase access to and the quality of care for CalOptima's older adult members. This includes supporting legislation as it relates to home- and community-based adult services, increasing access to LTSS and PACE, and supporting proposals within the Master Plan on Aging.

Medi-Cal Managed Care: Operations and Administration

California's Medi-Cal program is the largest state Medicaid program in the nation, insuring almost one-third of California's more than 38 million residents. In 2014, California opted to expand Medi-Cal eligibility under the Affordable Care Act, significantly increasing the number of Medi-Cal beneficiaries overall and in managed care plans. With CMS, the California Department of Managed Health Care and DHCS providing Medi-Cal oversight, there are myriad legislative issues, such as Knox-Keene licensure, Medicaid funding and health equity, that may have a direct impact on managed care plans.

Legislative Action: Support legislation and regulatory policies that benefit CalOptima and the County Organized Health Systems (COHS) model. This may include participating in proposed legislation and policies as they relate to the Affordable Care Act, the use of Intergovernmental Transfer Funds for non-covered Medi-Cal benefits, the Knox-Keene Act, maintaining Medicaid funding levels, and the Proposition 56 program.

Back to Agenda Back to Item

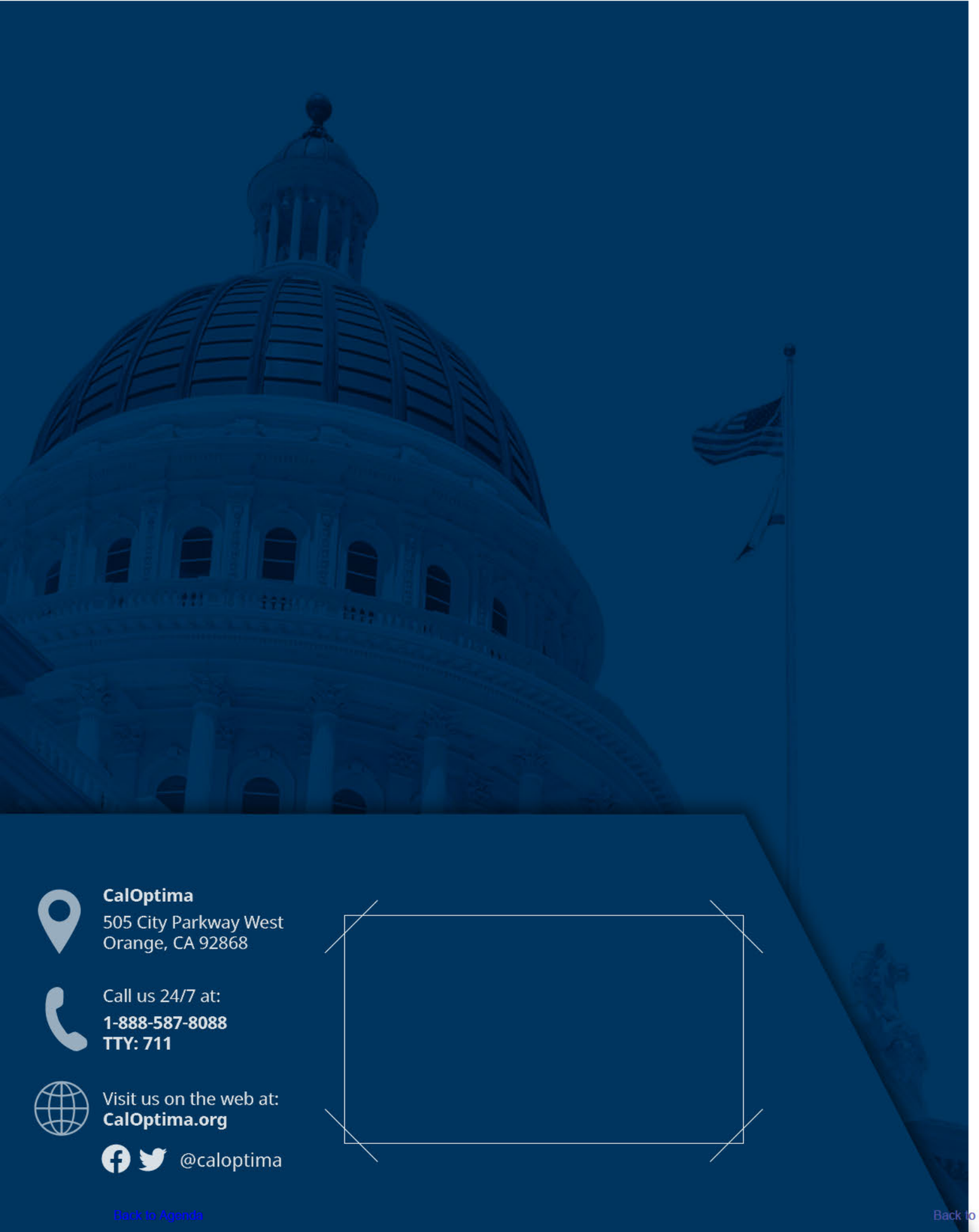
Legislative Platform

2021–22

CalOptima
A Public Agency
Better. Together.

Back to Agenda

Back to Item



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Back to Agenda

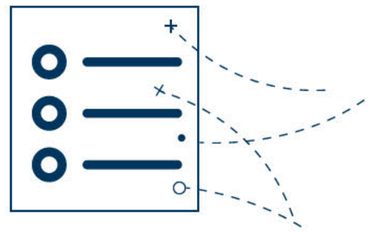


Table of Contents

Back to Item

About CalOptima

Mission

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

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

CalOptima Programs

Medi-Cal (California's Medicaid Program):

For low-income children, adults, seniors and people with disabilities. Most Medi-Cal members have incomes up to 138 percent of the federal poverty level.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan):

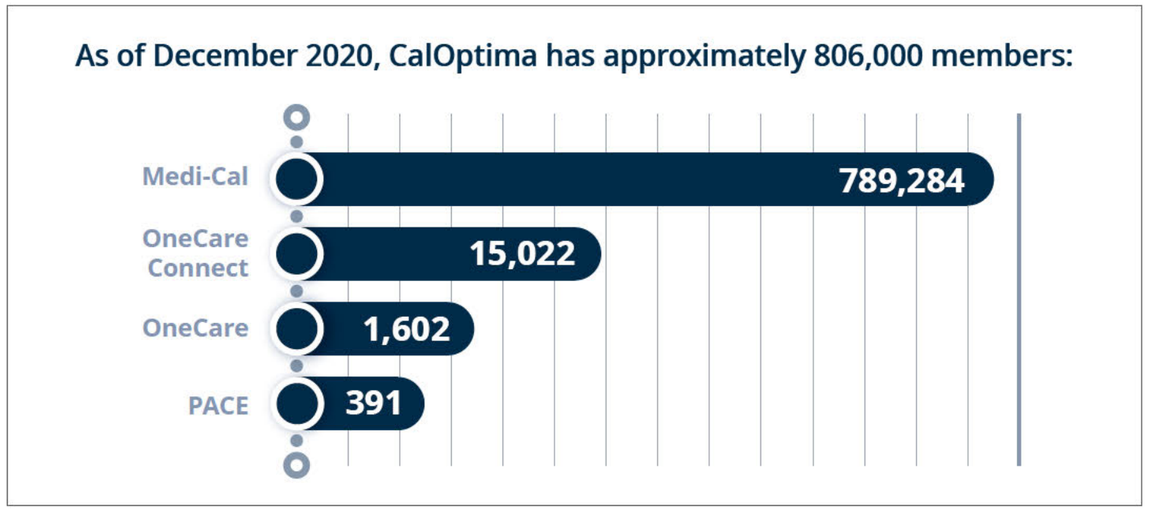
For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for worldwide emergency care, dental care (through the Medi-Cal Dental Program), vision care and fitness. Other benefits are transportation to medical services and a Personal Care Coordinator. To become a member of OneCare Connect, an individual must be age 21 and older, live in Orange County, have both Medicare Parts A and B and Medi-Cal, and must not be receiving services from a regional center.

OneCare (HMO SNP):

A Medicare Advantage Special Needs Plan (D-SNP), provides comprehensive care for low-income seniors and people with disabilities such as people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia), and who are dually eligible for Medicare and Medi-Cal. Most of the dually eligible individuals CalOptima serves are enrolled in OneCare Connect, but CalOptima continues to operate OneCare because not all members are eligible for OneCare Connect due to specific federal and state regulatory requirements.

Program of All-Inclusive Care for the Elderly (PACE):

A long-term comprehensive health care program that helps older adults remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. CalOptima PACE has a state-of-the-art facility in Garden Grove, California, that meets the vast majority of participant needs on site, from physical therapy to doctor appointments.



Platform Overview

CalOptima's 2021–22 Legislative Platform reflects the need to be responsive to a wide variety of federal, state and local legislative priorities and issues.

Back to Item

Overview

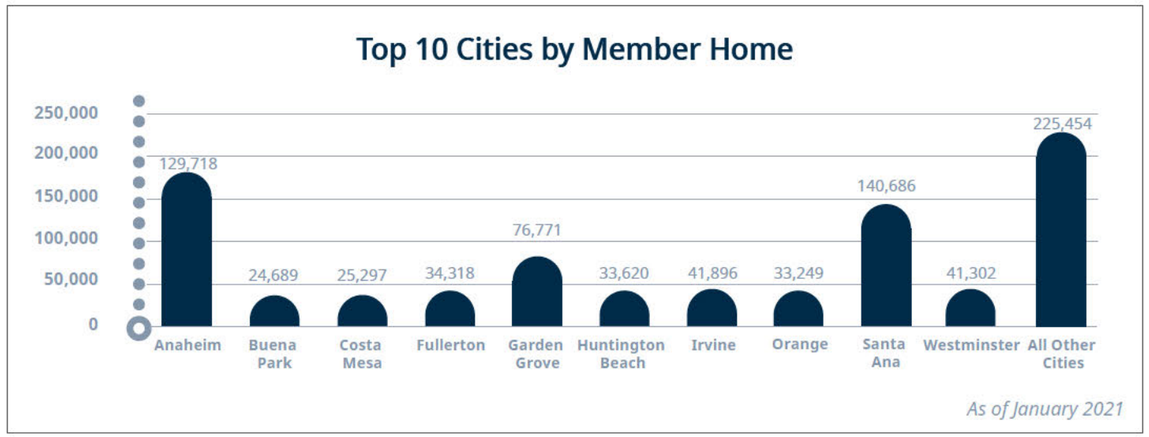
Political Landscape

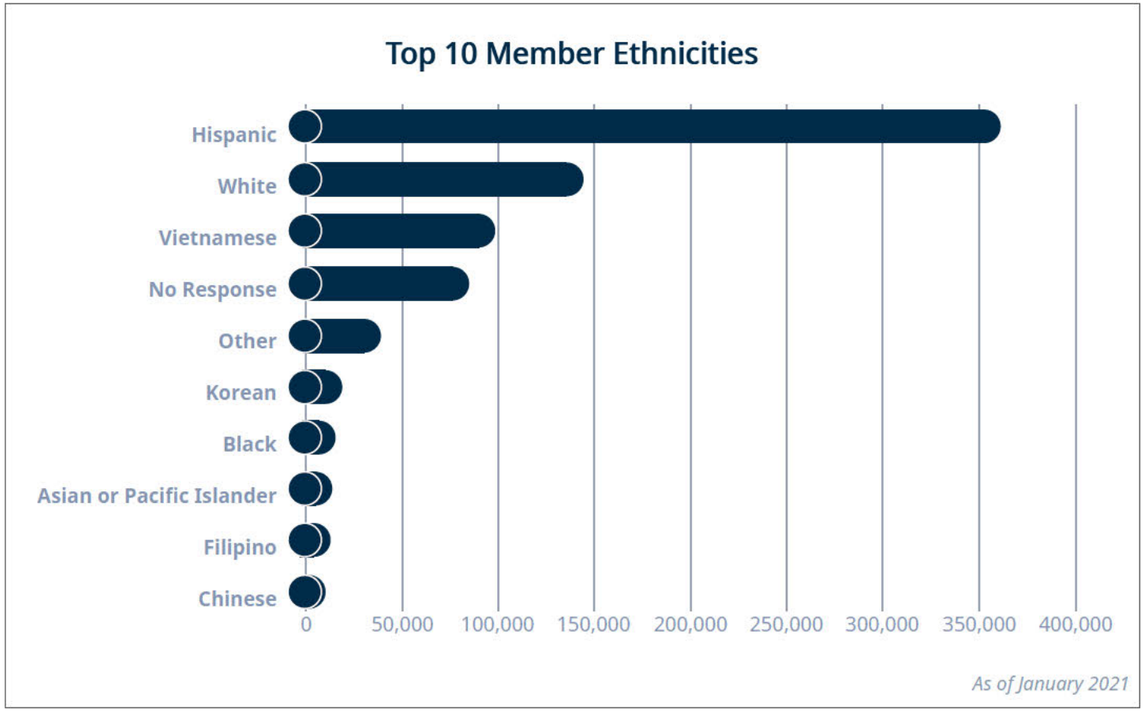
Federal and state health care policies continue to address the COVID-19 pandemic while strengthening and transforming the Medicaid program. Improving care for California's youth and older adult populations, increasing access to behavioral health services, utilizing telehealth, and working to end homelessness are among the top priorities. The Centers for Medicare & Medicaid Services is responsible for setting federal regulatory policies, overseeing Medicare and Medicaid, and funding California's Medi-Cal program, while Congress sets legislative priorities. Additionally, the California Department of Health Care Services and the State Legislature will continue to shape the future of health care in California during the 2021–22 legislative session.

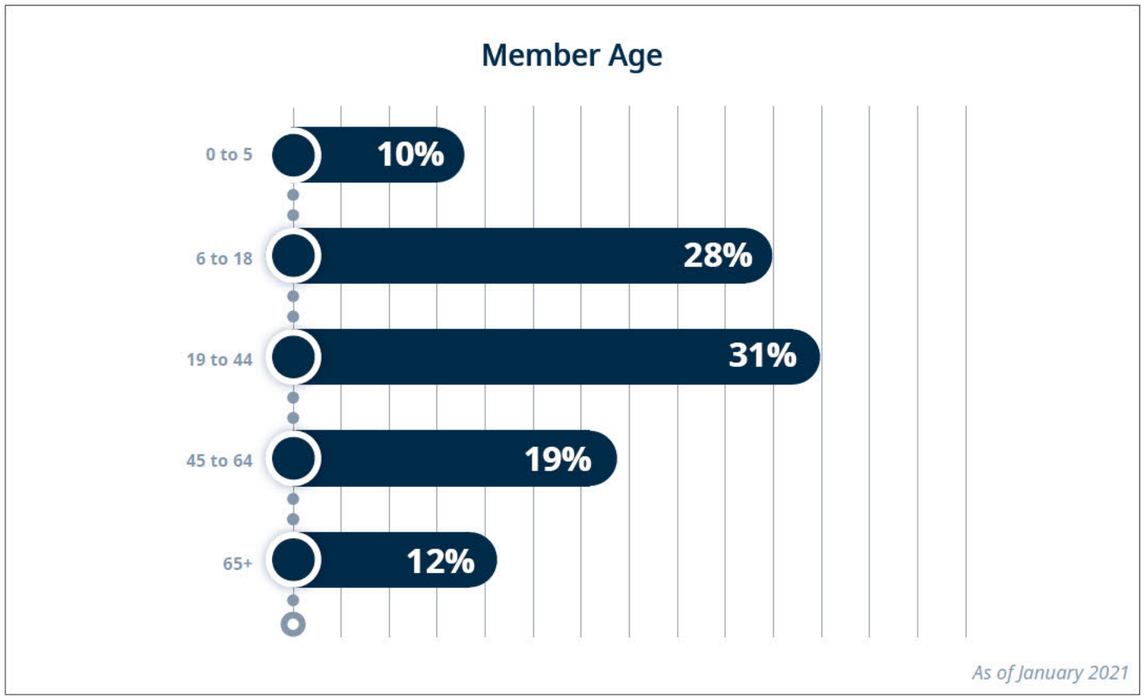
CalOptima is an integral part of the health care sector and business community in Orange County. As the sole Medi-Cal plan in the county, CalOptima is in a unique position to impact care delivery and partner with County agencies and other stakeholders to improve access to quality care for all members. Through federal, state and local advocacy, CalOptima will continue to respond to the public health emergency and focus on policy areas such as social determinants of health, telehealth, behavioral health and access to quality care.

CalOptima Demographic Information

As a County Organized Health System (COHS), CalOptima is the community-based health plan for Orange County's low-income individuals and families. More than 800,000 people - 1 in 4 Orange County residents - depend on CalOptima for access to health care.







Legislative Priorities

The 2021–22 Legislative Platform focuses on key issues that directly impact Medi-Cal managed care and CalOptima members and stakeholders.

- Response to COVID-19
- California Advancing and Innovating Medi-Cal (CalAIM)
- Social Determinants of Health
- Youth Services
- Older Adult Services
- Medi-Cal Managed Care: Operations and Administration

Note: Because the Legislative Platform is approved early in the legislative process, CalOptima may modify priorities as the session progresses.

Response to COVID-19

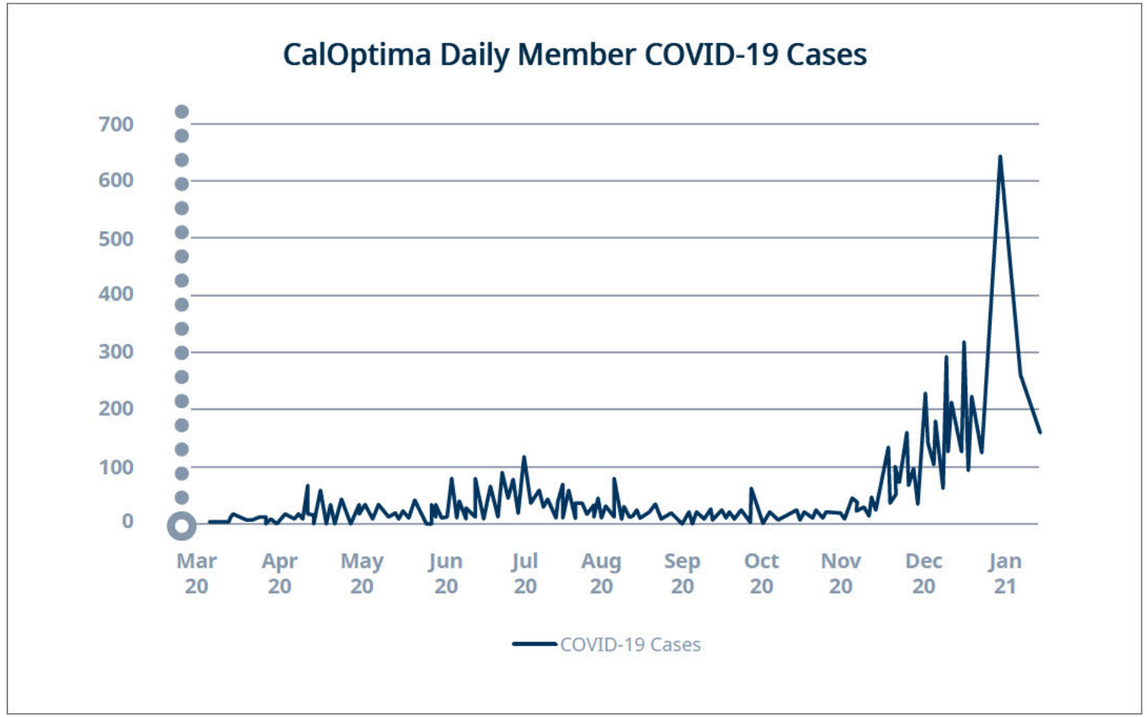
The COVID-19 pandemic has significant health and financial impacts on CalOptima members, providers, health networks and stakeholders. CalOptima members are medically and financially vulnerable, and they overwhelmingly reside in communities that have been hardest hit by the pandemic. As of January 2021, approximately 8,000 CalOptima members have tested positive for COVID-19, 3,400 members have been hospitalized, and nearly 450 members have died. In addition to having an impact on members' physical health, COVID-19 has impacted their mental health as well. It is anticipated that there will be an ongoing increase in behavioral health-related services as a result of the pandemic. CalOptima will continue to play a vital role in closing this health equity gap by ensuring timely, no-cost access to testing, treatment and vaccination for members. Likewise, CalOptima's contracted providers and health networks are critical partners in delivering these services to CalOptima members.

Response to COVID-19

Legislative Actions

Support legislation that advances care, treatment and services related to the COVID-19 public health emergency.

- **Behavioral Health (BH) in Response to COVID-19:** Support increased incentives and reimbursement for pediatric BH providers, in response to social isolation, distance learning and loss brought upon by the COVID-19 pandemic.
- **Provider Support:** Support efforts to ensure that providers have adequate funding, personal protective equipment and other resources to deliver care and meet members' health needs during the COVID-19 public health emergency.
- **Testing:** Support efforts to ensure that members have equitable access to COVID-19 diagnostic testing services at no cost.
- **Vaccine Distribution:** Support policies to ensure that members have equitable access to COVID-19 vaccines in a timely manner and at no cost, and that plans have access to vaccine administration data.



California Advancing and Innovating Medi-Cal (CalAIM)

On January 8, 2021, DHCS released its formal proposal for CalAIM, a multiyear initiative to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms. While the COVID-19 pandemic delayed the 2020 CalAIM proposal, Governor Newsom's Proposed State Budget includes $1.1 billion for Fiscal Year (FY) 2021–22 and $1.5 billion for FY 2022–23 to implement CalAIM.

CalAIM

Legislative Action

Support legislation and regulatory policies and proposals for CalAIM initiatives that benefit CalOptima's members relating to Enhanced Care Management, In Lieu of Services, Dual Eligible Special Needs Plan, Population Health Management, and Full Integration.

Enhanced Care Management and In Lieu of Services

The Whole-Person Care (WPC) program was authorized by CMS and DHCS as a pilot program within the Medi-Cal 2020 Waiver. Orange County's WPC program focuses on Medi-Cal members experiencing homelessness. Shortly after the launch of WPC, CalOptima launched Phases 1 and 2 of the Health Homes Program (HHP), which promotes access to the full range of physical, behavioral and social services for members with complex needs. California plans to incorporate segments of the WPC and HHP programs into CalAIM and transition these pilot programs into new statewide benefits that provide a broader platform for Medi-Cal members. In partnership with the Orange County Health Care Agency and community-based organizations, CalOptima is exploring proposals within CalAIM's Enhanced Care Management and In Lieu of Services initiatives.

Legislative Actions

- **Enhanced Care Management (ECM)**
  - → Support legislation and regulatory policies regarding ECM services, including the clarification of eligible populations.
- **In Lieu of Services (ILOS)**
  - → Support legislation and regulatory policies regarding ILOS services, including the clarification of eligible populations.
  - → Support legislation and regulatory policies to ensure ILOS program outcomes are in alignment with ECM, WPC, and HHP.

Dual Eligible Special Needs Plan

OneCare Connect (OCC) is CalOptima's Cal MediConnect program that combines Medicare and Medi-Cal benefits into one health plan. Due to delivery system carve-outs, Cal MediConnect plans were never able to integrate the full range of Medi-Cal benefits. Since CalOptima launched OCC as a pilot program on July 1, 2015, it has been extended over the years by both state and federal authorities. However, it is currently scheduled to end on December 31, 2022. CalAIM proposes to transition members into Dual Eligible Special Needs Plans (D-SNP) by January 1, 2023. CalOptima is evaluating the impact of moving approximately 14,700 OCC members into OneCare, CalOptima's D-SNP. Additionally, the CalAIM proposal has yet to determine if CMS or the plans will manage the transition of members into a D-SNP.

Legislative Action

- **Dual Eligible Special Needs Plans:** Advocate for plan flexibility to allow CalOptima to directly manage a seamless transition of beneficiaries from OneCare Connect to OneCare.

Population Health Management

In 2019, CalOptima adopted a Population Health Management (PHM) strategy as a comprehensive plan of action to address the needs of its culturally diverse membership in an equitable, holistic manner. The PHM strategy focuses on keeping members healthy, managing members with emerging risks and/or multiple chronic conditions, and improving patient safety and outcomes across all settings.[1] Because Medi-Cal managed care plans are not currently mandated to have a PHM strategy, DHCS has proposed requiring whole system, person-centered PHM strategies with standardized requirements across plans, including the implementation of wellness, prevention, case management and care transition programs.

Legislative Action

- **Population Health Management:** Support policies and funding that promote wellness, prevention and health equity.

Full Integration

DHCS plans to pilot the full integration of physical health, behavioral health and oral health under one contracted entity in a county or region. This would require multiple Medi-Cal delivery systems, including Medi-Cal managed care, county mental health plans and county Drug Medi-Cal Organized Delivery Systems, to be consolidated under one contract with DHCS. While few details have been considered or released, it is imperative that CalOptima plays a proactive role in the development of any integration plans, which are likely to have significant impacts on CalOptima operations and the delivery of care for members.

Legislative Actions

- **Coordination of Care:** Support policies that increase care coordination and data sharing across all delivery systems as well as remove barriers to accessing care.
- **Managed Care Benefits:** Oppose policies that would carve out any current managed care plan benefit.

Social Determinants of Health

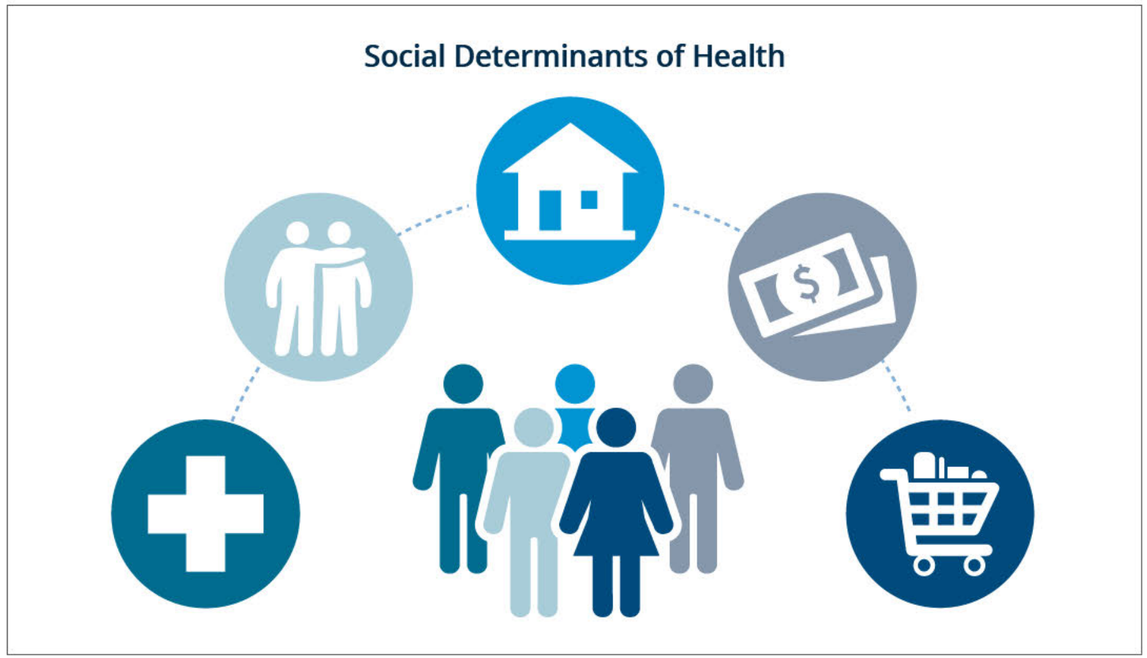
Social determinants of health (SDOH) are social, economic and environmental factors that impact an individual's health and well-being. These factors include but are not limited to hunger, childcare, housing, employment and family life. According to CalOptima's 2018 Member Health Needs Assessment Final Report, SDOH can either facilitate good health or act as barriers. CalOptima members have identified financial stressors, social isolation and safety concerns as significant factors affecting their health.[4] Additionally, CalOptima members experiencing homelessness have unique challenges accessing the traditional health care delivery system. In 2019, Orange County's Point in Time Count reported nearly 7,000 individuals experiencing homelessness. In response to these findings, CalOptima has taken steps to strengthen the safety net for members by expanding access to primary care services and releasing community grants to support programs addressing the SDOH of our members.

Social Determinants of Health

Legislative Actions

Support Medi-Cal funding for medical and non-medical services that address SDOH including but not limited to, food insecurity, nutrition, homeless health care initiatives, as well as housing and infrastructure.

- **Behavioral Health Services:** Support legislation that increases access to behavioral health and substance use supports and services for those experiencing or at risk of homelessness.
- **Field Teams:** Support legislation that increases access to mobile health care services for those experiencing homelessness.
- **Food Insecurity:** Support funding and policies that address food insecurity, in partnership with community organizations.
- **Housing and Infrastructure:** Support legislation that advances the development of supportive housing, crisis stabilization units and health care facilities, including addressing potential barriers created by the California Environmental Quality Act (CEQA).
- **Nutrition:** Support funding for healthy food items, with a physician order, to promote health and wellness.
- **Wrap-around Services:** Support legislation that includes wrap-around services for individuals experiencing homelessness, at risk of homelessness or experiencing housing insecurities, with a goal to provide health support and prevent chronic homelessness (e.g., WPC, ILOS, ECM, etc.).



Telehealth

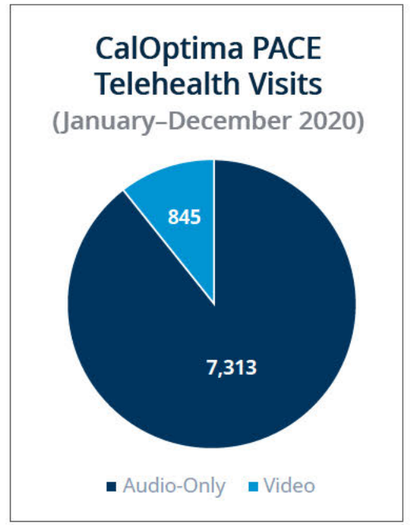
On March 16, 2020, in response to the COVID-19 pandemic, DHCS expanded access to telehealth services to ensure providers can deliver medically necessary health care services in a timely fashion for beneficiaries.[5] Temporary flexibilities, such as virtual assessments and audio-only telehealth calls, have contributed to an increase in access to providers and use of telehealth services. As a result, the number of CalOptima members who used telehealth services increased by 56,000 percent. In 2019, only 212 CalOptima members used telehealth compared with 120,718 members in 2020. Members and providers have expressed, making such flexibilities permanent would support the future of the health care delivery system as well as increase access for CalOptima's members.

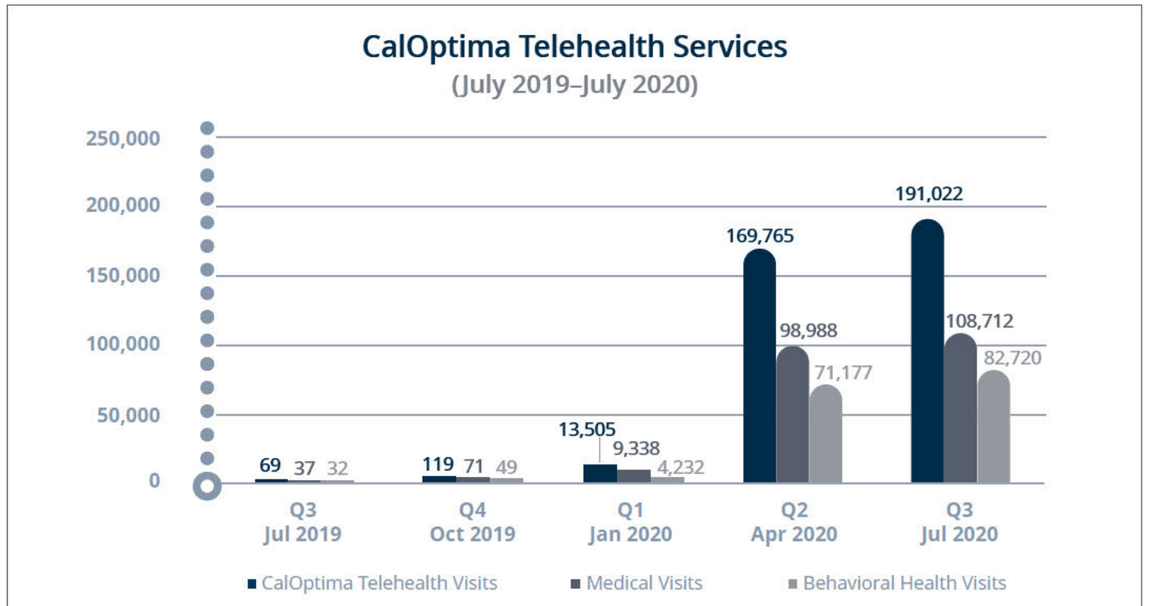
Telehealth

Legislative Actions

Support federal and state legislation and/or regulatory policies that expand access to telehealth services post the COVID-19 pandemic. This also includes advocating for the clarification of the difference in cost of care for delivering in-person services and telehealth services.

- **Flexibilities:**
  - → Support legislative and regulatory policies that continue the ability to conduct virtual assessments and audio-only telehealth services post COVID-19.
  - → Support equity by applying the same telehealth requirements for providers' offices, Federally Qualified Health Centers and Rural Health Clinics.
  - → Support the ongoing establishment of new patients via telehealth services.
  - → Support both traditional telehealth and other virtual/ telephonic communication modalities to help ensure access to care for members.
- **Payment Parity:**
  - → Advocate for clarification of the difference in cost of care for delivering in-person services and telehealth services.





Please note: this figure includes the most recent data reported, as of January 2021.

Youth Services

CalOptima's youth members are eligible to receive routine preventive care services, such as well-child visits; dental, vision and hearing care; behavioral health care and trauma screenings; and vaccinations. As of December 2020, there are approximately 310,000 CalOptima members who are under the age of 19. This includes 12,000 children with certain health conditions who receive care through the Whole Child Model program. CalOptima remains dedicated to providing coordinated, person-centered care for its youngest members.

Youth Services

Legislative Actions

Support legislation that increases access to and the quality of care for CalOptima's youth members as it relates to Adverse Childhood Experiences (ACEs), the Whole Child Model program, and support for members living with a developmental disability.

- **Adverse Childhood Experiences (ACEs):** Support legislation to allow Medi-Cal reimbursement for non-traditional trauma-informed services.
- **Developmental Disabilities:** Support legislative and budget proposals that improve the quality of care for CalOptima members living with a developmental disability.
- **Whole Child Model:** Support legislation that increases access to and the quality of care as it relates to the Whole Child Model program.

Older Adult Services

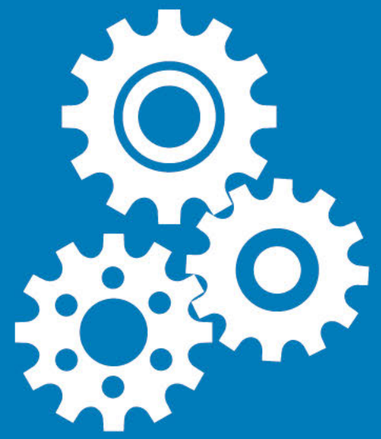
As of December 2020, CalOptima has nearly 96,000 members age 65 and older. CalOptima and its community partners provide person-centered care to older adults and seniors in need of complex care. This includes providing greater access to skilled care, increasing awareness for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) Center, and by facilitating transitions from a medical setting to a home-based setting. Implementing a person-centered care system may include the coordination of physical health, oral health, mental health, cognitive health, and Long-Term Services and Supports (LTSS), in addition to promoting full access and health equity.

Older Adult Services

Legislative Action

Support legislation and regulatory policies that increase access to and the quality of care for CalOptima's older adult members. This includes supporting legislation as it relates to home- and community-based adult services, increasing access to LTSS and PACE, and supporting proposals within the Master Plan on Aging.

- **Home- and Community-Based Adult Services (HCBS):**
  - → Support ongoing funding for HCBS, including Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), LTSS and In-Home Supportive Services (IHSS).
  - → Support legislative and regulatory policies that promote successful aging in place, ensuring older adults can remain safely in their homes.
- **LTSS:** Support legislative policies that promote the coordination of physical health, oral health, mental health and cognitive health for CalOptima members receiving LTSS.
- **Master Plan on Aging (MPA):** Support legislative policies and proposals that advance the MPA, a statewide blueprint that promotes and supports successful aging, and leverage Medicare to provide additional long-term services and supports for CalOptima's older adult population.
- **PACE**
  - → Support legislative priorities sponsored by CalPACE and the National PACE Association to increase awareness of, access to and utilization of PACE.
  - → Support regulatory policies that would expand services to additional at-risk populations, including individuals with severe mental illness and younger adults with physical disabilities.



Medi-Cal Managed Care: Operations and Administration

California's Medi-Cal program is the largest state Medicaid program in the nation, insuring almost one-third of California's more than 38 million residents.[6] In 2014, California opted to expand Medi-Cal eligibility under the Affordable Care Act, significantly increasing the number of Medi-Cal beneficiaries overall and in managed care plans. With both the California Department of Managed Health Care and DHCS providing Medi-Cal oversight, there are myriad legislative issues, such as Knox-Keene licensure, Medicaid funding and health equity, that may have a direct impact on managed care plans.

Medi-Cal Managed Care: Operations and Administration

Legislative Action

Support legislation and regulatory policies that benefit CalOptima and the County Organized Health Systems (COHS) model. This may include participating in proposed legislation and policies as they relate to the Affordable Care Act, the use of Intergovernmental Transfer Funds for non-covered Medi-Cal benefits, the Knox-Keene Act, maintaining Medicaid funding levels, and the Proposition 56 program.

- **Affordable Care Act:** Support policies that uphold and maintain the Affordable Care Act.
- **Intergovernmental Transfer (IGT) Funds:** Support legislation and/or regulatory policies that authorize the use of IGT Funds for non-covered Medi-Cal benefits.
- **Knox-Keene Act:** Oppose legislation that would require COHS plans to obtain a Knox-Keene license.
- **Medicaid Funding:** Oppose legislative and budget proposals that would reduce Medicaid funding at the federal and state levels, resulting in the elimination of optional benefits or other Medicaid programs.
- **Proposition 56:** Support legislative and budget proposals that continue Proposition 56 directed payments but modify the Value-Based Payment Program to ease administrative burden by using HEDIS (Healthcare Effectiveness Data and Information Set) measure definitions, specifications and physician practices.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions regarding the above information, please contact **GA@caloptima.org**

Endnotes

[1] CalOptima: Population Health Management (PHM) Strategy, February 2019
[2] Center for Health Care Strategies: California Health Care and Homelessness Learning Community, September 2020
[3] County of Orange: Orange County's 2019 Sheltered Point In Time Count, October 2019
[4] CalOptima: Member Health Needs Assessment Final Report, March 2018
[5] Department of Health Care Services, Medi-Cal Payment for Medical Services Related to the 2019-Novel Coronavirus (COVID-19), March 16, 2020
[6] Medi-Cal Managed Care: An Overview and Key Issues, Kaiser Family Foundation, March 2016

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

Back to Agenda
Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Receiving and Filing CalOptima's 2020 Quality Improvement Program Evaluation

Contacts
Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action
Receive and file the 2020 CalOptima Quality Improvement Program Evaluation

Background
The 2020 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities initiated in 2019 that impacted results in 2020, as well as activities undertaken during the first three quarters of the 2020 calendar year to improve health care and services available to CalOptima members. The 2020 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2021 QI Program and its Work Plan.

As a result of the COVID-19 pandemic. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance statements with flexibility in regulations addressing member access to care during the pandemic. These included Medi-Cal and Medicare telehealth options and requirements such as DHCS All-Plan Letter (APL) 19-009: Telehealth; APL 19-009 Supplement: Emergency Telehealth Guidance — COVID-19 Pandemic; and CMS' telehealth guidelines. The U.S. Department of Health and Human Services, Office for Civil Rights, also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but may be used in providing telehealth covered services during the COVID-19 pandemic.

CalOptima pivoted quickly in response to the pandemic, including acceleration of the Virtual Care Strategy, expanding access to virtual mental health care with trauma informed care capabilities, and implementing a hybrid approach to member outreach and education to ensure patient safety during the pandemic. CalOptima continued to focus on advancing QI initiatives to achieve 2020 QI goals and objectives to provide members with access to quality health care services in person or leveraging telehealth technology.

Discussion
Accomplishments in 2020

CalOptima achieved many of its organizational objectives in 2020:

- Recognized by DHCS as the highest performing Medicaid plan in California.
- All DHCS managed care accountability set (MCAS) measures required to achieve a Minimum Performance Level (MPL) were met in measurement year (MY) 2019, a significant achievement as

the DHCS raised the MPL from the 25th to the 50th national percentile for MY2019.

- Performed successful incentive outreach to members to obtain preventive care. In 2019 outreach programs demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, and breast and cervical cancer screening.
- CalOptima's comprehensive health network (HN) and CalOptima Community Network (CCN) Pay for Value (P4V) Performance Measurement Program continued to recognize and reward outstanding performance and support ongoing improvement aimed to strengthen CalOptima's mission of providing quality health care. The P4V program is a significant driver of our achievement of the MPL for all DHCS required measures.
- In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 for the Clinical Field Team (CFT) and Community Health Centers (CHCs). Telehealth visits were added due to COVID-19, while we continued providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots.
- CalOptima was accepted to participate in the *California Heath Care and Homeless Learning Community.* CalOptima's Homeless Health Initiative was selected in October 2020 among more than 40 applicants as one that stood out to the external review committee.
- The Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on October 1, 2020 to reduce post-acute infections at 25 nursing facilities of which 12 had already been participating in the University California, Irvine (UCI) study for Shared Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) of multi-drug resistant organisms (MDROs) since Q2 2017. In addition, CalOptima in partnership with UCI and the Orange County Health Care Agency (HCA), participated in the Orange County Nursing Home Infection Prevention program to create safety toolkits and instructional videos to reduce the spread of COVID-19 in nursing homes.
- Implemented a preventive care and flu campaign in response to the COVID-19 pandemic. CalOptima used a combination of interactive voice response (IVR) (landlines only), member mailings, on-hold messaging, educational videos on our member website and social media platforms and infomercials on Public Broadcasting Service (PBS) Kids.

In 2020, CalOptima implemented a robust population health management (PHM) strategy to focus on various conditions ranging from cancer screenings to managing patients with multiple complex conditions. The program had strong member and provider engagement, as indicated by quarterly monitoring. In response to the COVID-19 pandemic and amplification of health disparities for persons of color, CalOptima conducted a population segment analysis based on race and ethnicity. The results and opportunities to improve health equity will be incorporated in the 2021 QI Program. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2020 that will continue into 2021. These initiatives are focused on long-term improvement efforts for selected high priority measures.

Recommendations for 2021

Staff propose the following recommendations to be implemented in 2021:

1. Continue and expand member "health rewards" incentive programs by utilizing a contracted vendor experienced in increasing member engagement, specifically for preventive screenings. The vendor will offset use of intensive staff resources and facilitate expansion to other programs to narrow gaps in care. Work collaboratively with health networks to widen the promotion of member "health rewards" programs.
2. Intensify targeted member outreach, by utilizing multiple modes of communications per members preference, either through website, direct mailings, email, IVR calls, mobile texting,

on-site member outreach and member engagement activities such as a mobile mammography clinic, back-to-school wellness, and an adolescent health immunization clinic.

3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021.
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures.
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level, in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedying the lab data gap not currently available through limited contract data exchanges.
6. Expand the Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, e-visits, and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).
7. Continue to partner with UCI's Orange County Nursing Home Prevention Team to create on-line toolkits, videos, posters, and binder resources, as well as to offer webinars and consultative sessions to help stop the spread of COVID-19 in nursing homes.
8. Continue to offer the Post-Acute Infection Prevention Quality Incentive (PIPQI) to nursing facilities who administer the Chlorhexidine (CHG) antiseptic soap in order to reduce the number of nosocomial infections as well as acute care hospitalizations related to infections for LTC members.

During 2020, it has been a year of uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that will continue to impact lives locally, nationally and globally into 2021. Considering the appointment of three new members of the Board Quality Assurance Committee in 2020, the CalOptima QI Program and Work Plan for 2021 will be flexible to align with the new strategic goals and objectives as defined by the new Board of Directors.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions will enable CalOptima to continue to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
1. 2020 QI Program Evaluation

/s/ Richard Sanchez *03/24/2021*
Authorized Signature **Date**

Back to Agenda

2020

QUALITY IMPROVEMENT EVALUATION

2020 QUALITY IMPROVEMENT EVALUATION SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D., MMM, CHCQM **Date**

~~Interim~~ Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

TABLE OF CONTENTS

2020 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2020 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities initiated in 2019 which impacted results in 2020, as well as activities undertaken during the first three quarters of the 2020 calendar year to improve health care and services available to CalOptima members.

The final 2020 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2021 to the Quality Improvement Committee (QIC). The 2020 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2021 QI Program and its Work Plan.

The year 2020 is unprecedented as a result of the COVID-19 pandemic. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance's with flexibility in regulations addressing member access to care during the pandemic. It addressed Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth; APL 19-009 Supplement: Emergency Telehealth Guidance — COVID-19 Pandemic; and CMS' telehealth guidelines. The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services during the COVID-19 pandemic.

CalOptima pivoted quickly in response to the pandemic including acceleration of the Virtual Care Strategy, expanding access to virtual mental health care with trauma informed care capabilities, and implementing a hybrid approach to member outreach and education to ensure patient safety during the pandemic. CalOptima continued to focus on advancing QI initiatives to achieve 2020 Quality Improvement (QI) goals and objectives to provide members with access to quality health care services in person or leveraging telehealth technology.

CalOptima achieved many of its organizational objectives in 2020:

- Recognized by DHCS as the highest performing Medicaid plan in California.
- All DHCS managed care accountability set (MCAS) measures required to achieve a Minimum Performance Level (MPL) were met in measurement year (MY) 2019. This is a significant achievement as the DHCS raised the MPL from the 25th to the 50th national percentile for MY2019.
- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs which demonstrated improvements for HEDIS 2020, including well-child visits, postpartum care, breast and cervical cancer screening.
- CalOptima's comprehensive health network (HN) and CalOptima Community Network (CCN) Pay for Value (P4V) Performance Measurement Program continued to recognize and reward outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The P4V program is a significant driver of our achievement of the MPL for all DHCS required measures.

- In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). Telehealth visits were added due to COVID-19, while we continued providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots.
- CalOptima has been accepted to participate in the ***California Heath Care and Homeless Learning Community***. CalOptima's Homeless Health Initiative was selected in October 2020 among more than 40 applications, as one that stood out to the external review committee.
- Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on October 1, 2020 to reduce post-acute infections at 25 nursing facilities of which 12 were already participating with University California, Irvine (UCI) since Q2 2017 in the study for Share Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) of multi-drug resistant organisms (MDROs). In addition, CalOptima in partnership with UCI and the Orange County Health Care Agency (HCA), participated in the Orange County Nursing Home Infection Prevention program to create safety toolkits and instructional videos to reduce the spread of COVID-19 in nursing homes.
- Implemented preventive care and flu campaign in response to COVID-19 pandemic. CalOptima used a combination of interactive voice response (IVR) (landlines only), member mailings, on-hold messaging, educational videos to member website and social media platforms and infomercials on Public Broadcasting Service (PBS) Kids.

For 2020, CalOptima had adequate staffing, resources, and a well-defined quality committee structure in place to meet the required needs of the QI program. The QI program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution (GARS) Committee. The QIC had exceptional participation from external and internal practitioners as well as staff.

CalOptima implemented in 2020, a robust population health management (PHM) strategy to focus on various conditions ranging from cancer screenings to managing patients with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for persons of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity will be incorporated in the 2021 QI Program. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2020 that will continue into 2021. These initiatives are focused on long-term improvement efforts for selected high priority measures.

In 2021, based on the 2020 QI Program Evaluation, CalOptima will continue its PHM strategy in alignment with CalOptima's strategic priorities to focus on activities and incentives that will improve member engagement, access to care and quality outcomes.

Recommendations for 2021

1. Continue and expand member "health rewards" incentive programs by utilizing a contracted vendor experienced in increasing member engagement, specifically for preventive screenings. Vendor will offset use of intensive staff resources and facilitate expansion to other programs to narrow gaps in care. Work collaboratively with health networks to widen the promotion of member "health rewards" programs.
2. Intensify targeted member outreach, by utilizing multiple modes of communications per members preference, either through website, direct mailings, email, IVR calls, mobile

texting, on-site member outreach and member engagement activities such as (e.g. mobile mammography clinic, back-to-school wellness, adolescent health immunization clinic, etc.).
3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021.
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures.
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedy the lab data gap not currently available through limited contract data exchanges.
6. Expand Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, e-visits, and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).
7. Continue to partner with UCI's Orange County Nursing Home Prevention Team to create on-line toolkits, videos, posters, and binder resources, as well as offer webinars and consultative sessions to help stop the spread of COVID-19 in nursing homes.
8. Continue to offer the Post-Acute Infection Prevention Quality Incentive (PIPQI) to nursing facilities who administer the Chlorhexidine (CHG) antiseptic soap in order to reduce the number of nosocomial infections as well as acute care hospitalizations related to infections for LTC members.

During 2020, it has been a year of uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that will continue to impact lives locally, nationally and globally into 2021. Considering the appointment of three new members of the Board Quality Assurance Committee in 2020, the CalOptima QI Program and Work Plan for 2021 will be flexible to align with the new strategic goals and objectives as defined by the new Board of Directors. Staff will remain agile in the shifting health care landscape while continue to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

SECTION 1: QUALITY IMPROVEMENT PROGRAM STRUCTURE

Activities in the 2020 QI Program and associated Work Plan focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents

- **Annual Evaluation** — Completed a comprehensive evaluation of the QI program at the end of the fiscal year that assesses the performance of measures/indicators that are part of the QI program.
- **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI program by including "new initiatives" in the QI program description that will outline measurable goals and objectives that the organization is going to focus on in subsequent years.
- **Work Plan** — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year dependent on priorities and opportunities.
- **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members.

Reviews of QI Documents

- CalOptima successfully completed reviews of all of the above documents with the QI committees during 2020. The documents were reviewed and approved by the CalOptima Board of Directors.
- Feedback from the practitioners that participated in the QI committee meetings were included in program documents (i.e. Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

Provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.

- The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
- The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2020. This gave the QI department a framework on how to start implementing the QI program throughout 2020. For the remainder of the year, the QI staff updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on improving performance improvement activities directed towards clinical quality,

quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up, as appropriate.

- In 2020, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives like member outreach, provider education and outreach, incentives, educational materials, etc.
- The committee also reviewed and approved the policies and procedures as they were presented to the committee throughout 2020.
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); access to care; complaints and appeals; etc. Part of the feedback included specific actions that CalOptima could take to improve performance.
- The committee also received quarterly reports from the CPRC, UMC, MEMX, GARS, and WCM CAC. These reports were summarized and presented to the QAC quarterly in 2020.

Assessment of QI Staff and Resources

CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI program. In 2020, there were six additions to the QI department staff to support upcoming changes to the DHCS requirements for Facility Site Review as well as support staff for Potential Quality Issue (PQI) reviews. The QI department also received support from other key departments within the organization including, but not limited to, the following:

- Quality and Enterprise Analytics
- Population Health Management
- Behavioral Health Integration
- Case Management
- Member Services (including outreach and engagement)
- Provider Relations and Contracting
- Credentialing and Facility Site Review

Review of System Resources

CalOptima has dedicated significant resources to ensuring they have adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima has the capability to generate quality reports, gaps in care reports, physician feedback reports, and other relevant reports needed in the QI program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts that can support the reporting needs of the organization.

Overall Assessment of Program Structure

At the current time, CalOptima has adequate staffing and resources required to meet the needs of the QI program in addition to organizational program requirements. However, in 2021 it may need reallocating resources to address initiatives aimed at improving Member Experience especially timely access to care. CalOptima will continue to evaluate the needs of the program through the Work Plan on a quarterly basis and add staffing and additional resources, as needed to supplement the QI department. The organization receives adequate feedback from its community practitioners in

the development and implementation of the QI initiatives and programs through the different committees. CalOptima continues to have significant participation from the Medical Directors in the development and implementation of clinical initiatives and programs throughout the year. The Medical Director(s) and QI Directors report the information back up to Senior Leadership.

SECTION 2: QUALITY & SAFETY OF CLINICAL CARE

HEDIS Overview

CalOptima annually reports HEDIS for all lines of business (LOB). HEDIS enables "apples to apples" comparison of health plan care across six domains of care:

1. **Prevention**
2. **Access and Availability of Care**
3. **Utilization**
4. **Member Experience (CAHPS)**
5. **Health Plan Descriptive Information (such as membership, language and ethnicity of membership)**
6. **New measures using Electronic Clinical Data Sources (Adult Immunization Status, Prenatal Immunization Status and Depression Screening)**

These results are annually audited by certified HEDIS Compliance Auditors. All measures fully passed audit which gives CalOptima confidence in the reliability of the results which are used to inform our QI Program and initiatives.

These clinical quality measures are used to evaluate multiple aspects of patient care including preventive care, coordination of care, patient safety, and management of chronic conditions.

Overall Performance Highlights

- Medi-Cal
  - In 2019, the MPL for California Medicaid plans was raised from the 25th to the 50th National Medicaid percentile. CalOptima achieved the new MPL for all measures in measurement year 2019.
  - Several measures showed statistically significant improvement from the prior year. Examples include Well-Child Visits for 15 months, Prenatal and Postpartum Care, Adolescent Immunizations, and Use of Opioids from Multiple Providers. CalOptima had 69% of measures at the National Medicaid 50th percentile or higher.
  - P4V program measures showed improvement, but several are still below the 50th percentile.
  - Based on the review of rates, several measures were identified as an opportunity for improvement including asthma medication ratio, lead screening in children, and follow-up care for Children prescribed ADHD medication. These measures will be monitored in the 2021 QI Work Plan.

Key Measures for Medi-Cal

Focus on new MCAS measure set required by DHCS

Measures in red indicate a decrease from MY2019 performance

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019

Lead Screening in Children	90th	75th
Asthma Medication Ratio	75th	50th
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	50th	25th

Key Measures for OneCare Connect (OCC)
Measures targeted for improvement are key metrics below 3 Stars or the National Medicare 50th percentile

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	2 Star	2 Star
Follow-Up After Hospitalization for Mental Illness (OCC Quality Withhold)	25th	25th
Plan All-Cause Readmissions ages 65+ (OCC Quality Withhold)	1 Star	1 Star

Key Measures for OneCare (OC)

Measure	Quality Compass Percentiles Met	
	MY2018	MY2019
Care for Older Adults (Functional Status Assessment)	3 Star	2 Star
Plan All Cause Readmissions	1 Star	2 Star
Diabetes Eye Exams	4 Star	2 Star

Evaluation of 2020 Priority Initiatives

CalOptima Homeless Health Initiative

In 2020, CalOptima's Homeless Health Initiative extended the one-year pilot, launched in April 2019 through 2020, for the Clinical Field Team (CFT) and Community Health Centers (CHCs). In addition to providing on-call urgent care services and scheduled mobile and fixed site services at shelters and hot spots, telehealth visits were added due to the COVID-19 pandemic. The CFT received 801 calls from CalOptima's Homeless Response Team, which yielded 686 members being treated, of which 439 were CalOptima members. There have also been 138 referrals to recuperative care.

Since implementation, Homeless Clinical Access Program (HCAP) has onboarded nine community health centers of which seven are still actively participating. Since August 2019, HCAP has been in the field for over 1,500 hours, paid out $300K in provider incentives and has treated 1,228 homeless participants (CalOptima and non-CalOptima members).

Next steps include assessing COVID-19 impacts, determining ongoing needs and evaluation of data and outcomes.

P4V Program

CalOptima implemented a comprehensive HN P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The comprehensive P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board. Annually, the CalOptima staff conducts a review of the current measures and their performance over time.

Based on a 2018 retrospective longitudinal QI performance review, although CalOptima consistently met the MPL, overall quality performance trends have been flat over the past five years. This trend is

very consistent with the California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009–2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, 59% remained unchanged or declined. CalOptima's HNs provided feedback including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data.

Based on the feedback, a new methodology has been adopted for MY2020–2021, which aims for greater transparency, consistency, and administrative simplification. The new HN Quality Rating (HNQR) methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, CMS Star Rating Status, newly required DHCS MCAS and/or overall NCQA Health Plan Rating. This new methodology was approved by the CalOptima Board of Directors in February 2020. The new methodology also received approval from the CalOptima Board of Directors to double the per member per month (PMPM) incentive to network providers and HNs for the P4V program.

Evaluation of Initiatives for Specific HEDIS Measures

This evaluation of quality initiatives focuses on activities performed in 2019 on priority measures identified in the QI Work Plan and to impact the HEDIS 2020 (MY2019) rates. This evaluation also describes current 2020 quality initiatives and gives preliminary insight as to barriers and lessons learned that inform the development of the 2021 QI Work Plan.

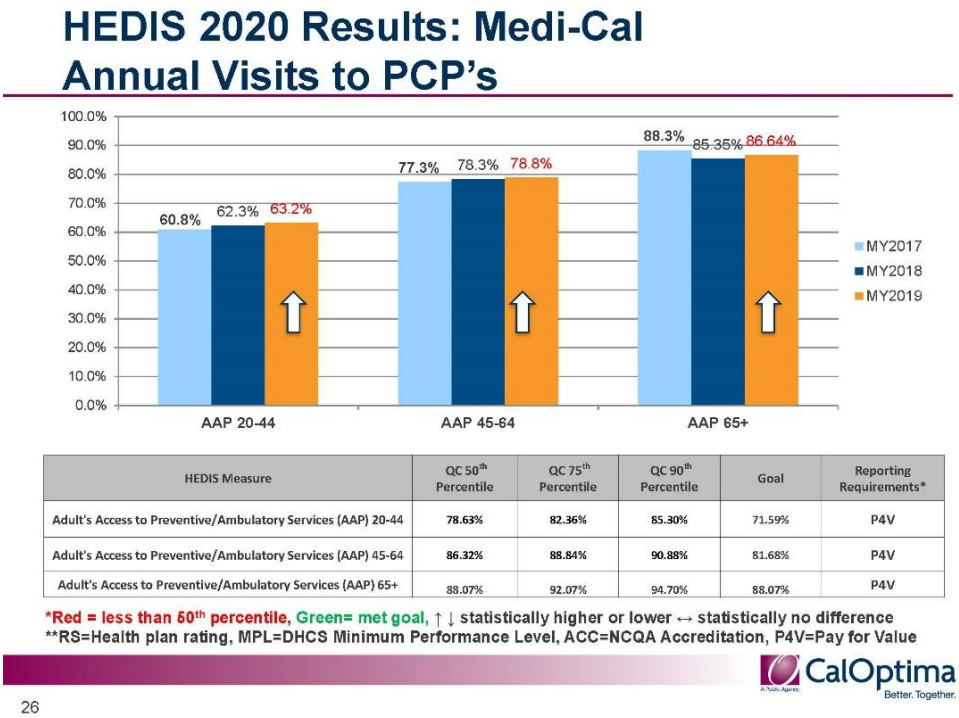
Please note: All HEDIS results equate to the prior MY, e.g., HEDIS 2020 refers to MY2019. All graphs reflecting HEDIS 2020 Results show a trend analysis for MY2017–2019.

Kaiser members were excluded from this program evaluation since the QI Program and activities are fully delegated to Kaiser, thus they were not included in CalOptima quality initiatives. Please note, however, that Kaiser members *are* included as part of the HEDIS 2020 final rate calculations.

Adult's Access to Preventive/Ambulatory Services (AAP): Medi-Cal

The table below shows a trend analysis for Medi-Cal Adult's Access to Preventive/Ambulatory Services (AAP) for the MY 2017–2019. The rates have steadily increased for AAP the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic. This measure is incentivized in our P4V program and has helped the improvement of this measure.

AAP Table: Trending HEDIS Rates MY2017–2019 Results: Medi-Cal



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Services (AAP) 20-44	78.63%	82.36%	85.30%	71.59%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 45-64	86.32%	88.84%	90.88%	81.68%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 65+	88.07%	92.07%	94.70%	88.07%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

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26

2019 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness. This program is monitored by the Program Manager, and data collection is tracked and monitored monthly. It is important to continue implementing the program activities as it is still in the infancy stage.
- Promoted the preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure by engaging members to access health care services. For more information, refer to the breast cancer screening, cervical cancer screening and colorectal cancer screening sections.

2020 Adult's AAP Initiatives: Medi-Cal

- Implemented HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.
- Promotion of preventive health care services such as breast cancer screening, cervical cancer screening and colorectal cancer screenings for the appropriate age groups and populations. These activities subsequently impacted the AAP measure.

Barriers

- Due to the COVID-19 pandemic, there was a drop in well-care visits during March–August 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community is reluctant to go in for their routine well-care visits and immunizations due to COVID-19. CalOptima will continue our efforts to promote well-care visits during this time.

Opportunities for Improvement

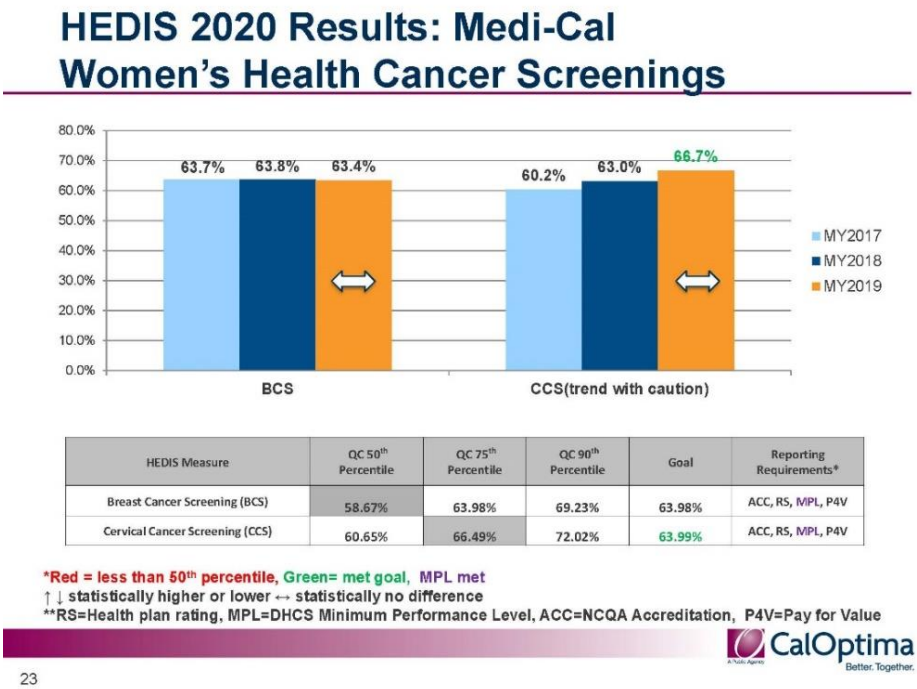
- Continue to promote appropriate well-care visits and immunizations for adults during this time.
- Continue the HCAP services for person experiencing homelessness in Orange County.
- Continue with implementing appropriate member and provider incentive (the term "health reward" is used interchangeably) programs for 2021 to increase preventive health care screenings and tests.
- Keep as a QI Work Plan priority due to catch up that will need to occur due to COVID-19.
- Consider developing a general well care visit member incentive or anticipatory guidance to promote preventative visits in light of member hesitation due to COVID-19.
- Leverage alternative member outreach modality such as mobile text messaging to promote well care visits safely.

Preventive Health Screenings (BCS/CCS/COL)

Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS): Medi-Cal

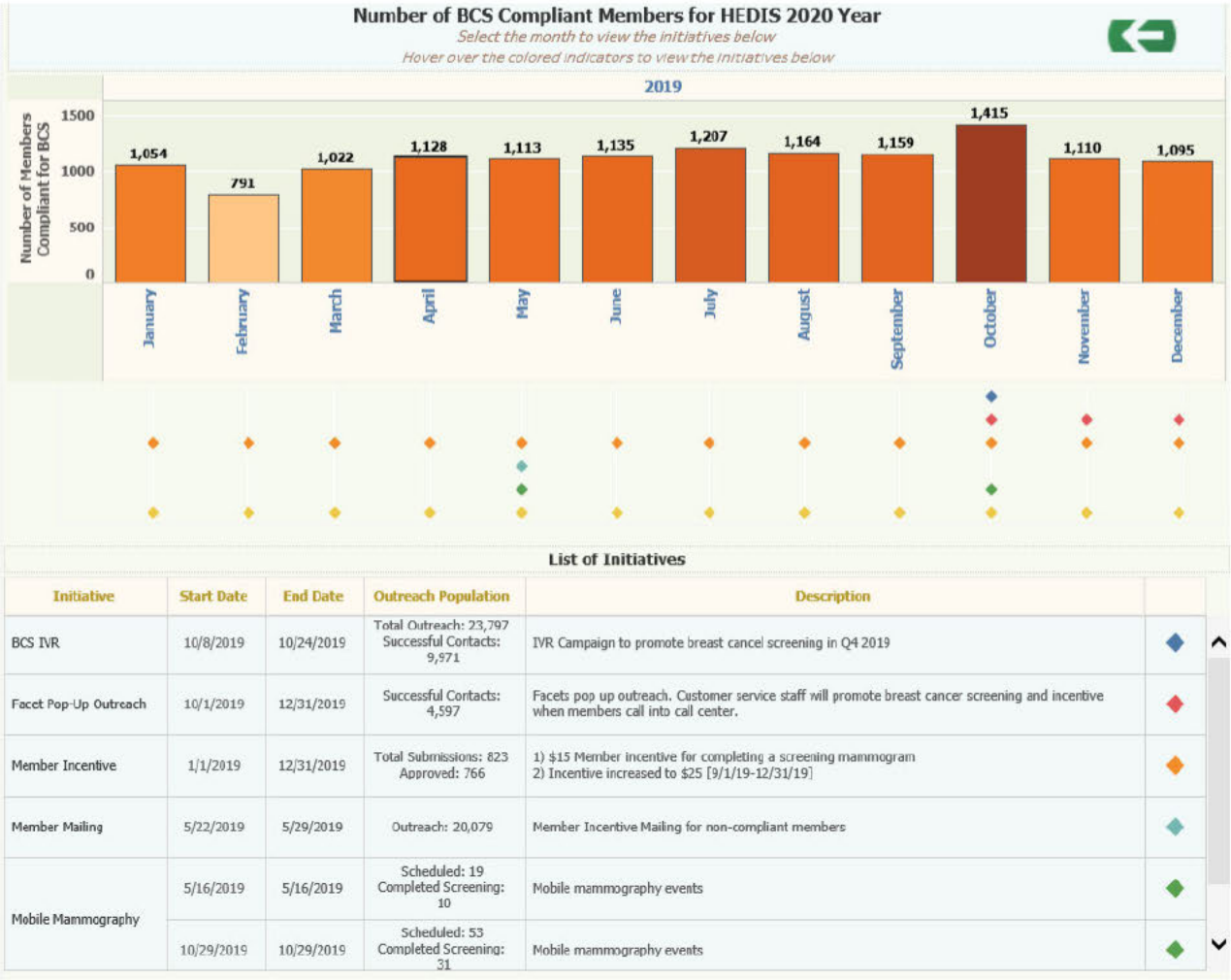
In 2020, CalOptima had initiatives for BCS and CCS cancer screenings. The table below shows a trend analysis of Medi-Cal BCS and CCS for the last three MY2017–2019. The rates have been steady for BCS but show improvement for CCS. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

BCS/CCS Table 1: Trending HEDIS Rates MY2017-2019 Results: Medi-Cal



BCS Table 2: Impact of BCS Targeted Interventions on HEDIS 2020 Year: Medi-Cal

The table below shows the number of unique members who received a BCS mammogram month by month and the impact of interventions throughout the year. While the rate remained steady throughout the year, the month with the highest jump in BCS screenings occurred in October 2019, right after the amount of the member incentive raised from $15 to $25. In addition, IVR outreach, FACETS member outreach and mobile mammography initiatives all took place in October 2019. Breast Cancer Awareness month also in October.



2019 BCS Initiatives: Medi-Cal

1. BCS Member Incentive 01/01/2018–12/31/2019

A. Description

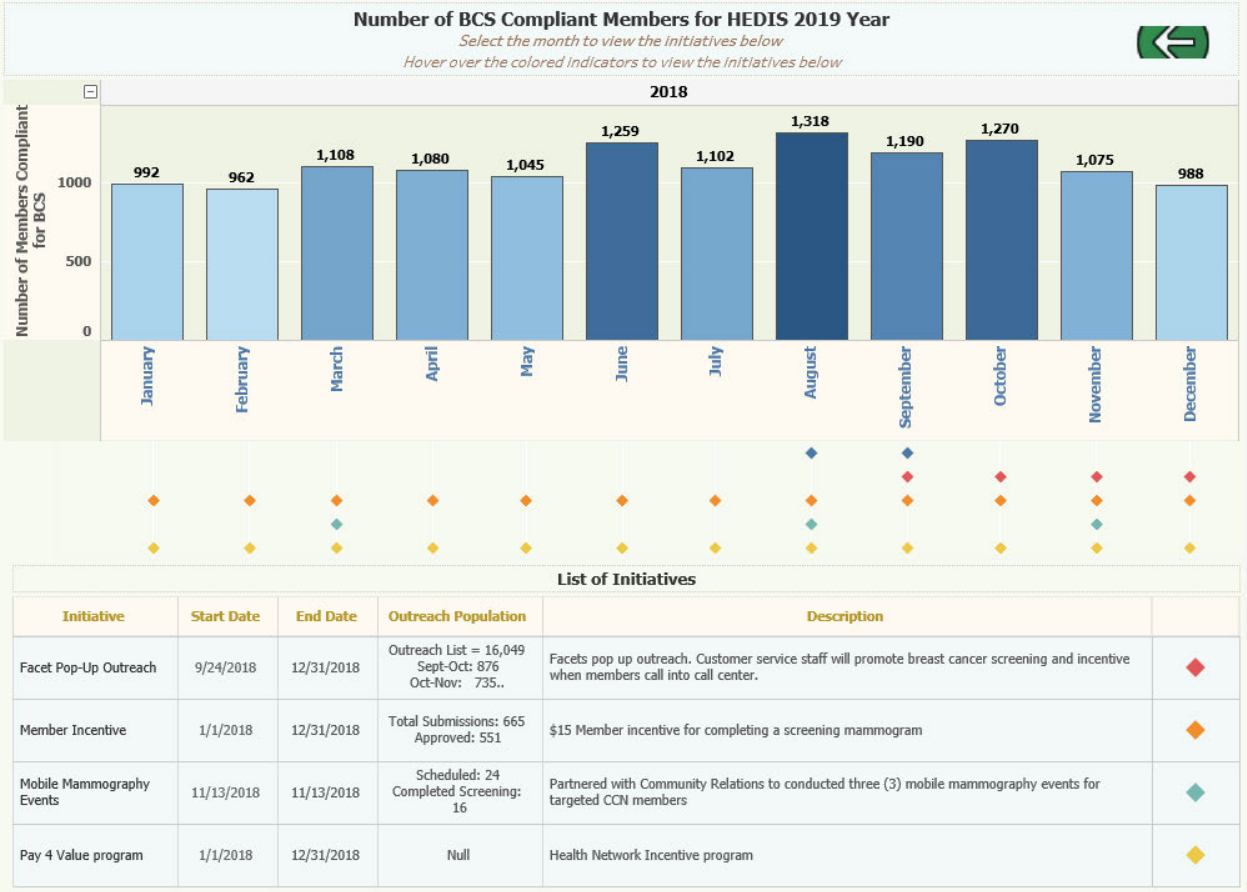
In August 2018, 16,340 eligible Medi-Cal members ages 50–74 were mailed a BCS incentive form for a $15 gift card. In May 2019, 20,079 CalOptima Medi-Cal members ages 50–74 identified as needing a screening mammogram completed before 12/31/2019, were mailed a $15 incentive form in May 2019. The incentive amount was changed in September 2019 from $15 to $25. The mailing was not repeated due to limited budget for mailing; however, members were made aware of the incentive via IVR robocall campaign.

BCS Table 3: Breast Cancer Screening Incentive Mailing MY2018–MY2019

BCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	16,340	626	482	32,059	1.50%
2019	20,079	753	594	32,940	1.80%

NOTE: The HEDIS denominator was used to calculate the participation rate.

BCS Table 4: The table below shows the BCS initiatives for the HEDIS 2019 (MY2018) year. The data shows a steady number of members compliant for BCS throughout the year with only a slight rise in August 2018 when the BCS member incentive form was mailed to eligible members.



List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Facet Pop-Up Outreach	9/24/2018	12/31/2018	Outreach List = 16,049 Sept-Oct: 876 Oct-Nov: 735..	Facets pop up outreach. Customer service staff will promote breast cancer screening and incentive when members call into call center.
Member Incentive	1/1/2018	12/31/2018	Total Submissions: 665 Approved: 551	$15 Member incentive for completing a screening mammogram
Mobile Mammography Events	11/13/2018	11/13/2018	Scheduled: 24 Completed Screening: 16	Partnered with Community Relations to conducted three (3) mobile mammography events for targeted CCN members
Pay 4 Value program	1/1/2018	12/31/2018	Null	Health Network Incentive program

B. Analysis

1. In 2018, of the 16,340 members mailed the incentive form in August 2018, 14,521 remained in the denominator for the HEDIS 2019 BCS measure. Of those, 1,603 members completed a BCS after the mail drop date with a rate of 5.00% (1,603/32,059). Of the 626 BCS incentive form submissions, 482 BCS incentive form submissions remained in the BCS measure denominator. The incentive participation rate for the HEDIS 2019 BCS measure was 1.50% (482/32,059).
2. In 2019, of the 20,079 members mailed the incentive form in May 2019, 16,823 were part of the HEDIS denominator for the HEDIS 2020 BCS measure. Of those mailed the incentive a total of 753 BCS incentive forms were received, 594 members were in the BCS measure denominator. The incentive participation rate for the HEDIS 2020 BCS measures was 1.8% (594/32,940). Of the 594 HEDIS eligible forms there were 493 forms date of service (DOS) matched our claims/encounters data while 101 forms DOS did not match with a rate of 83.00%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

C. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until the end of Q1 every year. Additionally, it is unknown which percentage of mail is returned due to wrong addresses.
2. The member incentive form requires a signed/stamped attestation by the primary care provider (PCP) or imaging center. This may prevent some members from participating in the BCS incentive, on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $15 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact.

D. Opportunity for Improvement

1. Due to the late September 2019 change of the dollar amount of the incentive, continue the BCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Enhance the BCS member by utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams.
3. Messaging can be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race. Utilize Gaps in Care outreach nurses.

2. BCS FACETS Member Outreach 10/01/2019–12/31/2019

A. Description

Target CalOptima Medi-Cal members ages 50–74 that were non-compliant for BCS that have placed an inbound call to CalOptima for another need. Customer Service staff had an opportunity to promote the importance of BCS to a captive audience/member that need to complete BCS. Also, members notified of the incentive opportunity available for completing a screening mammogram.

B. Analysis

1. Customer Service was able to deliver the FACETS pop-up message to 4,597 non-compliant members. Of the 4,597 members that were targeted 1,920 members were in the denominator for the HEDIS 2020 BCS measure.
2. The rate of members that received the message for HEDIS 2020 BCS measure was 5.83% (1,920/32,940). Of the members who received the FACETS pop-up message, 133 members completed a BCS after receiving FACETS pop-up message with a rate of 0.40% (133/32,940).

C. Barriers

1. This intervention is only available to members who called into the Customer Service line and likely already proactive about their health. It is uncertain if the FACETS pop-up message was the only reason member would complete their BCS.

D. Opportunities for Improvement

1. Continue BCS FACETS member outreach as part of a more robust member communication/touchpoint plan.
2. Expand the duration of the BCS FACETS member outreach or also conduct initiative earlier in the MY as well.

3. **BCS IVR Outreach 10/08/2019–10/24/2019**
   A. **Description**
      Member outreach campaign targeted eligible CalOptima Medi-Cal members ages 50-74 that were non-compliant for BCS to encourage completion of a BCS.

   B. **Findings**

BCS Table 5: This table shows the results of non-compliant members that were targeted for the BCS IVR call campaign.

2019 BCS IVR Outreach	Successful IVR Calls	Unsuccessful IVR Calls	Total IVR Calls	Rate of Successful IVR Calls
BCS IVR Call Campaign	9,971	13,826	23,797	41.90%
HEDIS 2020 BCS Measure	1,299	11,870	13,169	9.86%

   C. **Analysis**
      1. Of the 23,797 total IVR calls made, 9,971 of the calls were listened to or completed, a rate of 41.90% (9971/23797). Of the 23,797 members that were targeted 13,169 were in the denominator for the HEDIS 2020 BCS measure. The rate of successful IVR calls for the HEDIS 2020 BCS measure was 9.86% (1,299/13,169).

   D. **Barriers**
      1. Unsuccessful IVR call was largely due to the member hanging up the call before the message was completed, no answer/busy and bad number.

   E. **Opportunities for Improvement**
      1. Expand member outreach modality beyond BCS IVR call campaign as the only method to notify members when they are due for BCS.
      2. Continue BCS IVR call campaign as part of a more robust member communication/touchpoint plan.
      3. Re-design BCS IVR call campaign to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
      4. Make use of mobile text messaging and IVR campaigns in 2021.

4. **Breast Cancer Screening (BCS) Mobile Mammography 05/16/2019; 10/29/2019**
   A. **Description:** Targeted eligible CCN Medi-Cal members ages 50–74 to complete BCS at a planned mobile mammography event at two locations. Members that attended and completed BCS received $20 gift card.
      1. Mobile mammography event held on 05/16/2019 at the Nhan Hoa Comprehensive Health Care Clinic. Mobile mammography event held 10/29/2019 at the CalOptima Westminster Satellite Office.
      2. BCS mobile mammography data was used to evaluate how many members completed BCS at one of the mobile mammography events and were included in the denominator for the HEDIS 2020 BCS measure.

B. Findings

BCS Table 6: This table shows the results of non-compliant members that were targeted for BCS mobile mammography.

BCS Mobile Mammography	Scheduled	Completed BCS Screening	HEDIS 2020 Denominator	Completed BCS Screening
BSC Mobile Mammography (Combined events)	72	41	--	--
HEDIS 2020 BCS Measure	53	28	32,940	0.09%

C. Analysis

1. Of the 72 members that were scheduled, 53 members were in the denominator for the HEDIS 2020 BCS measure. Of the 72 scheduled, 41 completed the screening. Of the 53 in the denominator, only 28 completed the screening. The rate of members that completed BCS through the event against the overall denominator for the HEDIS 2020 BCS measure was 0.09% (28/32,940).

D. Barriers

1. 43% of the scheduled members did not attend the event. The intervention is resource intensive and takes extensive planning across internal departments. Due to contractual limitations with the mobile mammography vendor, the event could only accommodate a relatively small volume of members.
2. Qualitative feedback from attendees showed significant value of bringing the service out to the community albeit it being resource intensive to support a traditionally difficult-to-reach portion of the membership.

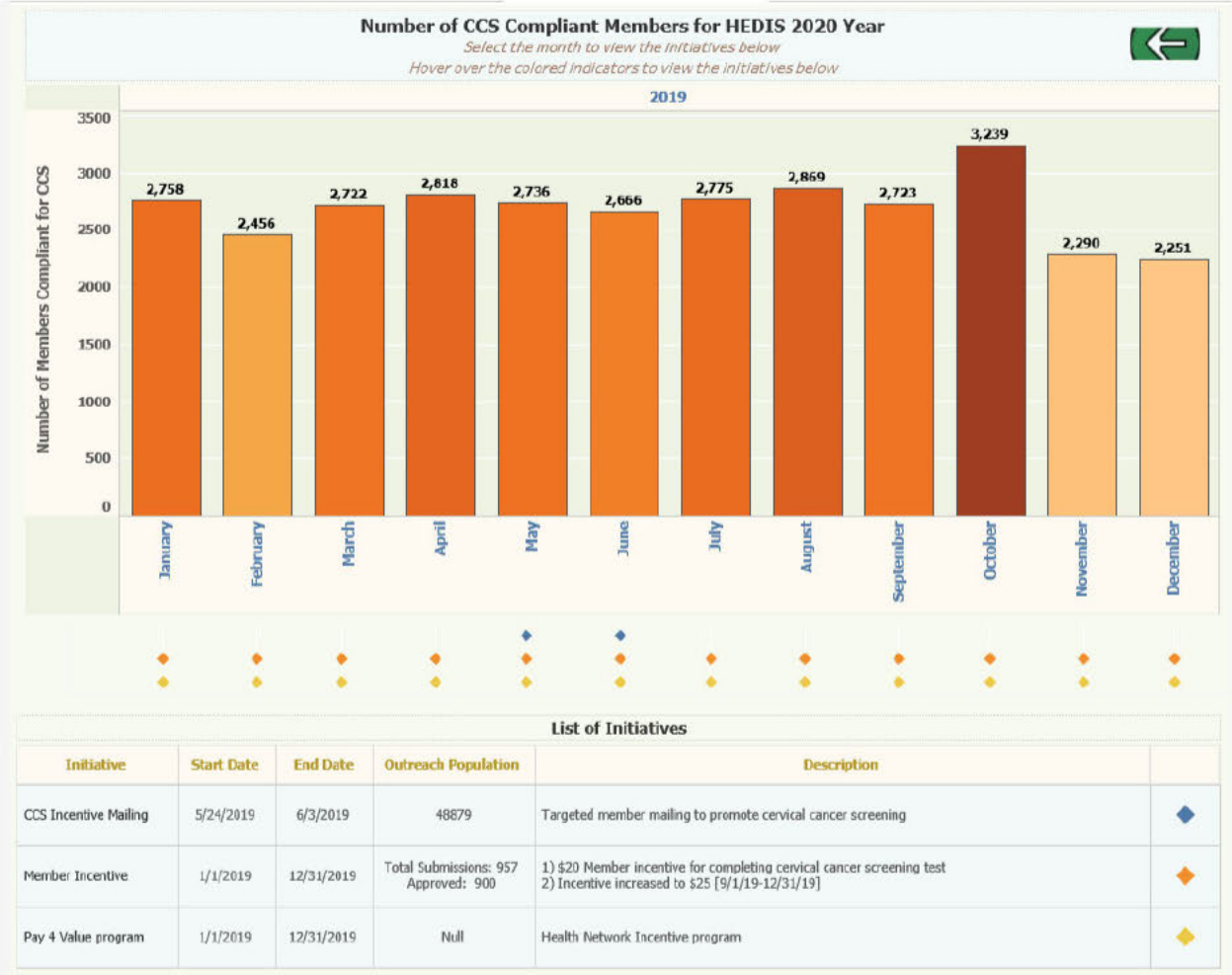
E. Opportunities for Improvement

1. Explore a less resource intensive mechanism to solicit and include qualitative feedback from attendees
2. Adapt mobile mammography events to reach greater volume of members likely to engage in geographic locations or places of gathering, possibly leveraging CalOptima's nearby imaging centers that can accommodate higher volume.

2019 Cervical Cancer Screening Initiatives: Medi-Cal

CCS Table 2: Impact of CCS Targeted Interventions on HEDIS 2020 Rates: Medi-Cal

The table below shows the number of unique members who received a pap test and the impact of interventions throughout the year. The data shows a steady number of members compliant for CCS throughout the year. The highest number of cervical screenings occurred in October 2019 when the CCS member incentive dollar amount increased from $20 to $25.



1. Cervical Cancer Screening (CCS) Member Incentive 01/01/2018–12/31/2019

A. Description

In August 2018, 66,675 eligible Medi-Cal members ages 21–64 were mailed a CCS incentive form for $20 gift card. In May 2019, 48,879 CalOptima Medi-Cal members ages 21–64 identified as needing a cervical cancer screening or pap test completed before 12/31/2019 were mailed a $20 incentive form. The incentive amount was changed in September 2019 to $25. The mailing was not repeated due to limited budget for an additional mailing; however, members were made aware of the incentive via IVR robocall campaign.

B. Findings

CCS Table 4: Cervical Cancer Screening Incentive Mailing MY2018–MY2019

CCS Incentive Forms	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2018	66,675	745	699	119,220	0.57%
2019	48,879	963	705	117,422	0.60%

NOTE: The HEDIS denominator was used to calculate the participation rate.

C. Analysis

1. In 2018, of the 66,675 members mailed the incentive form in August 2018, 56,767 remained in the denominator for the HEDIS 2019 CCS measure. 4,618 members completed a CCS after the mail drop date with a rate of 3.87% (4,618/119,220). Of the 745 CCS incentive form submissions, 699 CCS incentive form submissions remained in the CCS measure denominator. The incentive participation rate for the HEDIS 2019 CCS measure was 0.57% (699/119,220).
2 In 2019, of the 48,879 members mailed the incentive form in May 2019, 36,548 were part of the HEDIS denominator for the HEDIS 2020 CCS measure. Of those mailed the incentive, 3873 completed a screening after the mail drop with a rate of 3.30% (3,873/117,422). Of a total of 963 CCS incentive forms received, 705 members were in the CCS measure denominator. The incentive participation rate for the HEDIS 2020 CCS measures was 0.60% (705/117,422). Of the 705 HEDIS eligible forms there were 607 forms DOS matched our claims/encounters data while 98 forms DOS did not match with a rate of 86.10%.
3. Although the participation rate increased from MY2018 to MY2019, it was minimal. Considering there was no additional interventions, other than the one-time mailing, and very little promotion, the low participation rate was expected.

D. Barriers

1. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until Q2 every year. It is unknown which percentage of mail is returned due to wrong addresses as well.
2. The member incentive form requires a signed/stamped attestation by the PCP or imaging center. This may prevent some members from participating in the BCS incentive on top of a perceived aversion and negative perception of the mammogram experience.
3. The low dollar amount of the incentive may not have been a big enough incentive, therefore the adjustment from $20 to $25 in September 2019.
4. Incentive was not communicated effectively to members or providers resulting in low incentive participation.
5. The merging of multiple interventions in October 2019 makes it unclear which intervention had the most impact. A 2020 mailing to all members due for a pap test in 2020 was delayed from the original intended date in March 2020 to August 2020 due to deliberate delays in having members come in during the height of the COVID-19 pandemic.

E. Opportunities for Improvement

1. Continue the CCS incentive through 2020 and 2021 to allow more time for members to be aware of the incentive programs offered.
2. Expand member outreach beyond CCS member mailing. Heightened promotion of the CCS incentive utilizing multiple modes of communication via website, direct mailings, IVR calls and mobile text messaging and more direct collaboration with CCN providers and HN quality teams is recommended in 2020 and 2021 to see the impact and trend of incentive enhancements.
3. Redesign messaging to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
4. Utilize Gaps in Care outreach nurses.

2020 Breast Cancer Screening and Cervical Cancer Screening Initiatives: Medi-Cal

- BCS and CCS incentive mailing originally scheduled for March 2020 was delayed and mailed in August 2020 to all eligible members who were due for a BCS or CCS. To address concerns about urging preventative screenings raised by HNs, a COVID-19 disclaimer was added to all mailings encouraging members to have the discussion about any risks and to determine the best care plan for each member weighing the risk against the benefits.
- Continued monitoring and tracking member incentive for both BCS and CCS screening measures.
- Collaborate and coordinate outreach efforts with HN quality teams on call, IVR and mailed campaigns. Some HNs agreed to promote CalOptima incentives.
- Promote member incentives through website, HN and provider update faxes and communications, incentive posters for medical offices.
- IVR campaign for the CCS population in January 2020 to align with the national monthly observances.

Barriers

- Due to the COVID-19 pandemic, preventive care visits began declining in March 2020. CalOptima's June 2020 prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Members are afraid of the procedure itself and other members are afraid of the result. Both barriers are related to member understanding of the tests and treatment options available.
- Incentives were not loaded to the CalOptima website until March 2020 due to design and approval delays.
- Incentives were not mailed to target populations in March 2020 as scheduled due to COVID-19 and were delayed until August 2020.
- BCS IVR campaign scheduled for May was put on hold due to surge in COVID-19 cases, and the need to adjust messaging to include safety precautions in light of the pandemic.

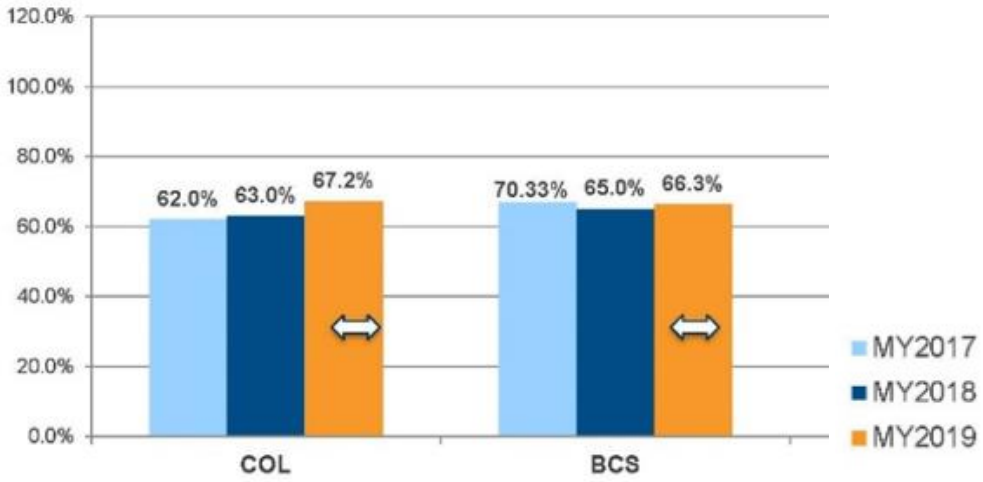
Opportunities for Improvement

- Despite negligible improvements in incentive participation rates for BCS and CCS, considering the minimal amount of outreach in MY2018 and MY2019, and due to the late nature of the upgrade for both incentives to $25, the incentive program should run through 2020-2021 to see how wider marketing and promotion in working directly with HNs and high volume providers for both incentives may impact utilization and rates.
- Retain these measures on the 2021 QI Work Plan and continue to focus on preventive care screenings including BCS and CCS to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of $25 incentives for the BCS and CCS screenings appealing to the importance of not delaying due to COVID-19 and the financial benefit of the $25 gift card.

Breast Cancer Screening (BCS) and Colorectal Cancer Screening (COL): OC and OCC

The table below shows a trend analysis for OCC BCS and COL for MY2017-2019. The rates have slightly increased for BCS from 2018 to 2019. The rates for COL have gradually increased from 2017–2019. However, we anticipate some decline in the 2020 MY rates due to the COVID-19 pandemic.

HEDIS 2020 Results: OneCare Connect Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star, P4V
Breast Cancer Screening (BCS)	66%	76%	83%	66%	Star, P4V

2019 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

- CalOptima offered a $25 breast screening incentive and a $50 colorectal cancer screening incentive as two new health rewards (health reward and incentive are used interchangeably) to the Medicare population late in September 2019. To qualify for the BCS incentive program, a member must complete a screening mammography in 2019 in order to receive a $25 health reward. To qualify for the COL incentive program, a member must complete either a sigmoidoscopy or colonoscopy in 2019 in order to receive a $50 health reward. The response rates for these programs was close to zero due to a late launch in the year and no official mailing sent to eligible members due to delays with form graphic design and approval through CMS. The forms were not made available on the CalOptima website until March 2020.

2020 Breast Cancer Screening and Colorectal Cancer Screening Initiatives: OC and OCC

Continued monitoring and tracking member incentive for both screening measures.

- Official launch of new $25 OC/OCC breast cancer screening and $50 OC/OCC COL member incentives in January 2020 with HN and CCN provider notifications.
- Fillable PDF forms posted on the CalOptima website in March 2020.
- Incentive article in OCC member newsletter in Summer 2020 issue.

Barriers

- Due to the COVID-19 pandemic, there was a drop in preventive care screenings starting March 2020. CalOptima's 2020 rate reports continue to show a decline when compared to the same time last year. The community is reluctant to go in for their preventive care screenings due to COVID-19.

- Members are afraid to know the result of the tests and avoid getting screened because of that fear.
- COVID-19 added to another level of fear to get preventive care services as members have stayed away from any kind of clinic visits.
- IVR campaigns were put on hold due to a surge in COVID-19 cases to prioritize pandemic safety precautions.

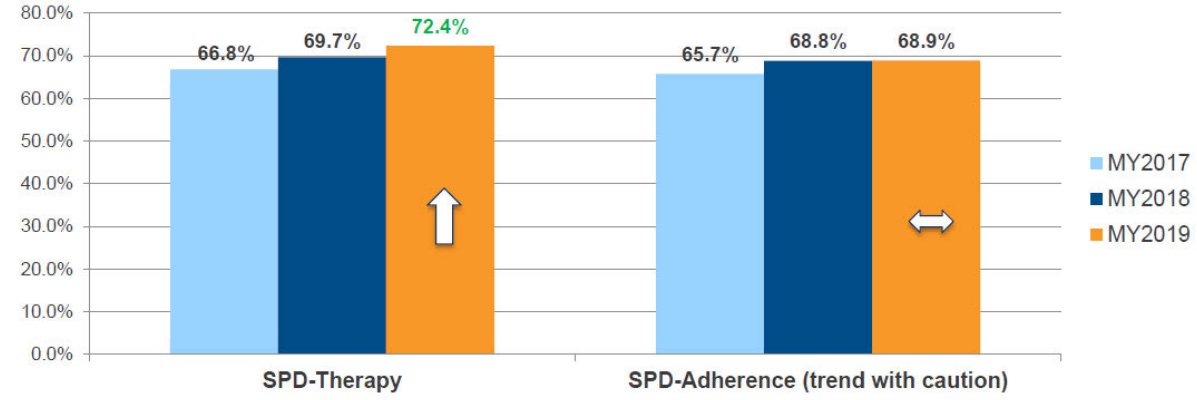
Opportunities for Improvement

- Continue both member incentives for the OC and OCC populations.
- Due to new barriers experienced by COVID-19 this year, CalOptima will retain both BCS and COL measures on the 2021 QI workplan and continue to focus on preventive care screenings to address expected dips in utilization through multi-media awareness messaging and communications.
- Expand messaging and promotion of both screening incentives appealing to the importance of not delaying due to COVID-19 and the financial benefit of the gift cards.

Statin Therapy for Patients with Diabetes (SPD)

The table below shows a trend analysis for Medi-Cal SPD measure for MY2017–2019. SPD-therapy sub measure met the MPL goal for MY2019 reaching the 90th percentile MPL. Although we did not meet goal for the SPD-adherence sub measure MY2019, we did achieve the 75th percentile satisfying the MPL. However, some decline is anticipated in the 2020 MY rates due to the COVID-19 pandemic.

SPD Table 1: HEDIS Trending Rates 2017–2019



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.65%	67.19%	70.19%	70.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	71.00%	ACC, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2020 Statin Therapy for Patients with Diabetes (SPD) Initiatives: Medi-Cal, OC and OCC

1. Pharmacy Department SPD Provider Faxes 2019-2020

A. Description

CalOptima's Pharmacy department sent a list of members to providers for member outreach in order to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggested non-adherence.

SPD Table 2a and b: Pharmacy Department SPD Provider Faxes 2019–2020

QTR	Date of Fax	Total Member Count Included in Fax	# of Included MCAL Members	# of Included OC Members	# of Included OCC Members
1Q19	3/27/19	7,905	7,125	69	711
2Q19	5/23/19	9,292	8,333	94	865
3Q19	8/16/19	7360	6,429	115	816
4Q19	11/20/19	8,603	8,584	19	726

Pharmacy Department SPD Provider Faxes 2020												
Number of Members Faxed to Providers												
	Quarter 1 2020				Quarter 2 2020				Quarter 3 2020			
Sub measure	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total	MCAL	OC	OCC	Total
Statin Needed	3,176	42	397	3,615	4,166	56	516	4,738	3,861	53	447	4,361
Statin Non-Adherence	2,489	22	266	2,777	1,823	13	206	2,042	2,225	35	297	2,557
Total	5,665	64	663	6,392	5,989	69	722	6,780	6,086	88	744	6,918

2. Quarterly SPD Member Mailings

A. Description

In an effort to reinforce the SPD provider faxes, a quarterly complementary member mailing was created to educate members with diabetes who are not on a statin medication or non-adherent to have the conversation with their PCP about whether a statin was right for them to reduce cardiovascular risk as a precautionary safety measure. The mailing included this message and information about statin medications. PHM sent quarterly mailings to members to improve SPD Statin Therapy and Statin Adherence measures. Identified members were either not currently on a statin medication or had an adherence rate <80% of their statin medication. Since 2019 was a planning year for this initiative, the data was finalized in November 2019 The mailer first dropped in Q1 2020 and included a cover letter prompting

the member to ask their doctor if a statin medication is right for them along with a member material about statin medication.

SPD Table 3: SPD Quarterly Member Mailings

	SPD Member Quarterly Mailings					
	Q1 2020			Q2 2020		
LOB	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**	**Targeted Non-Compliant Members Sent Letter**	**Compliant Members After Mailing**	**Compliance Rate by Next QTR**
OC	40	32	80%	8	5	63%
OCC	276	146	53%	125	46	37%
Medi-Cal	2334	1006	43%	1007	278	28%
Total	**2650**	**1184**	45%	**1140**	**329**	29%

B. Analysis

- In Q1 2020, the compliance rate by next quarter was 80% for OC, 53% for OCC and 43% for Medi-Cal. Overall, there was a 45% compliance rate across the lines of business, by the next quarter. In Q2 2020, the compliance rate by next quarter was 63% for OC, 37% for OCC and 28% for MC and overall, we had a 29% compliance rate by the next quarter in Q2 2020. Compliance rates improved most significantly for OC members, likely because these members had greater medical needs and were more consistently under a physician's direct care.

C. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications with diabetes.

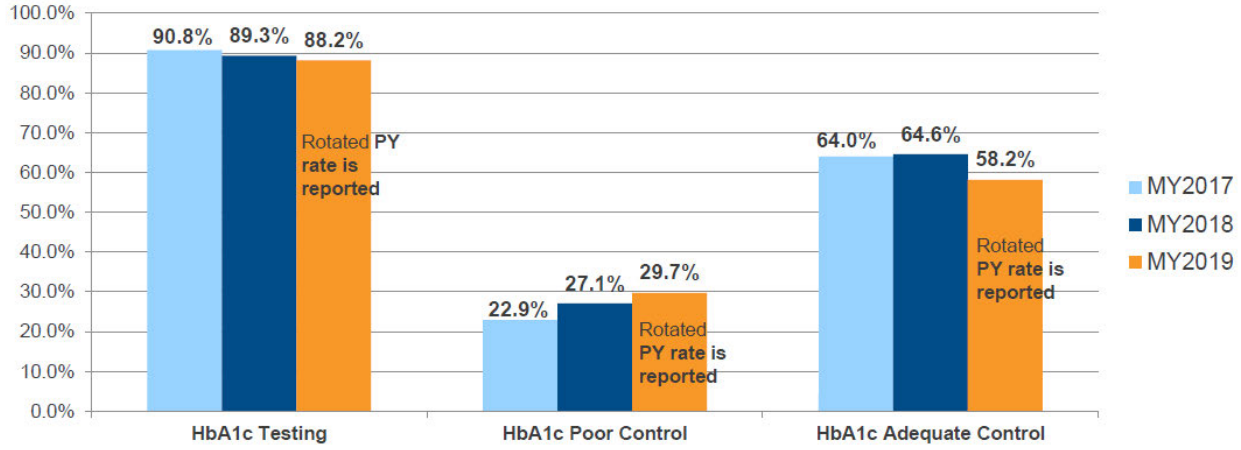
D. Opportunities for Improvement

1. Due to moderate success in affecting compliance, the quarterly faxes will continue to be sent to providers of their diabetic and quarterly member mailings to newly identified diabetic members who are not currently on a statin medication. The provide are an additional layer of support to other efforts to prevent cardiovascular risk among the diabetic population and promote safety.
2. Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
3. Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
4. Continue newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Comprehensive Diabetes Control (CDC): A1C Testing and Eye Exam

The table below shows the trend analysis for Medi-Cal Comprehensive Diabetes Care (CDC) HbA1c measure for the years 2017–2019. HbA1c Poor Control met the 75th percentile surpassing the MPL (lower is better). HbA1c Adequate Control sub measure met the 75th percentile.

CDC Table 1: HbA1cTesting and Control

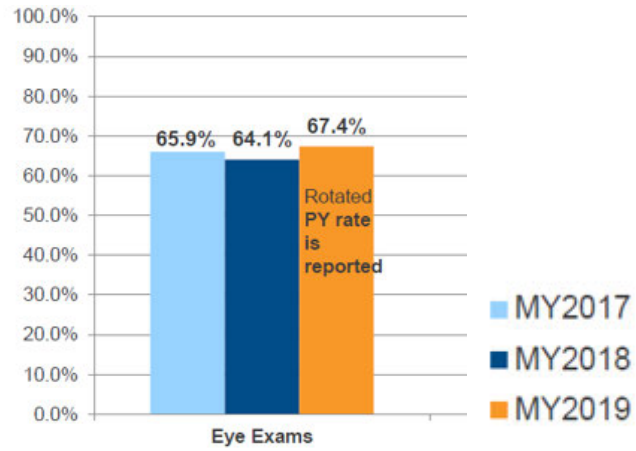


HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	88.55%	90.51%	92.94%	89.78%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.52%	32.85%	27.98%	27.98%	MPL
HbA1c Adequate Control (<8.0%) ++	50.97%	55.96%	60.77%	60.77%	ACC, RS, P4V

*Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
*RS=Health Plan Rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

CDC Table 2: Eye Exam

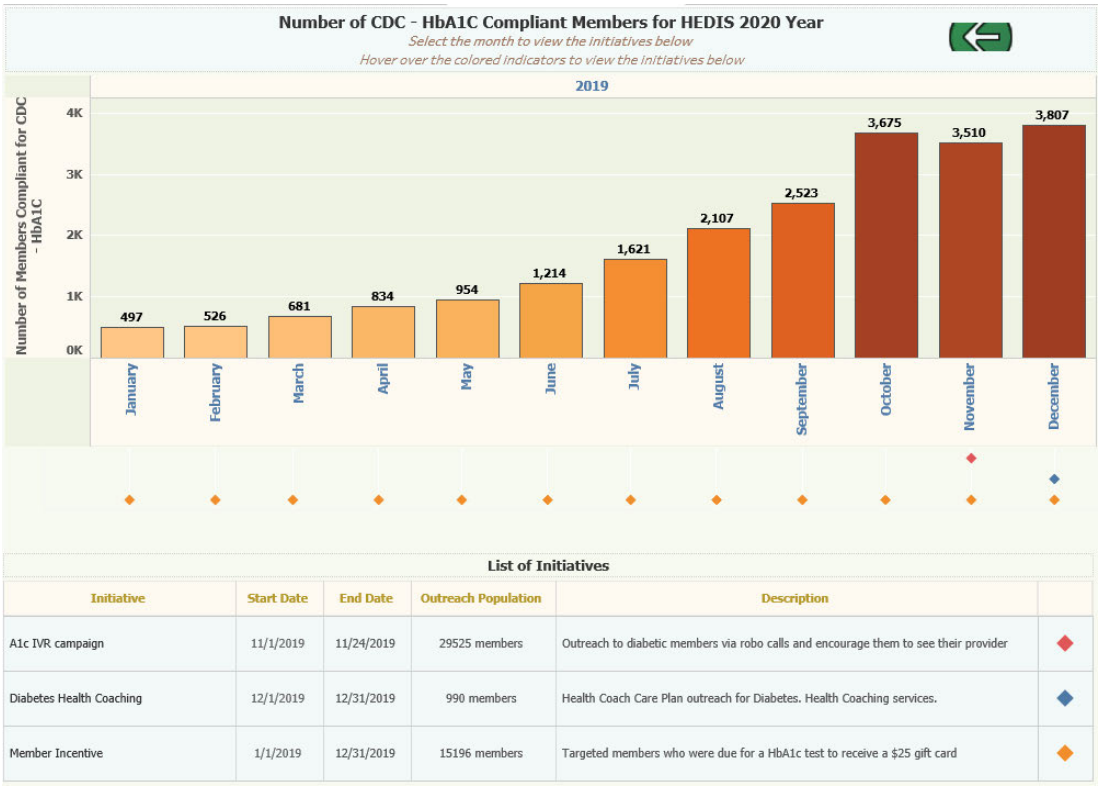
The table below shows the trend analysis for the Medi-Cal CDC Eye Exam measure for MY2017–2019. Eye Exam measure met the 50th percentile meeting the MPL.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Eye Exams	57.88%	64.23%	68.61%	64.72%	ACC, RS, P4V

CDC Table 3: HbA1C Compliant Members for HEDIS 2020

The table below shows the HbA1C initiatives for the HEDIS 2020 (MY2019) year. The data shows a gradual increase month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. A slight decrease occurred in November 2019. The HbA1c IVR campaign deployment in November 2019 as well as the implementation of the Diabetes Health Coaching initiative helped with increasing member compliance in December 2019.



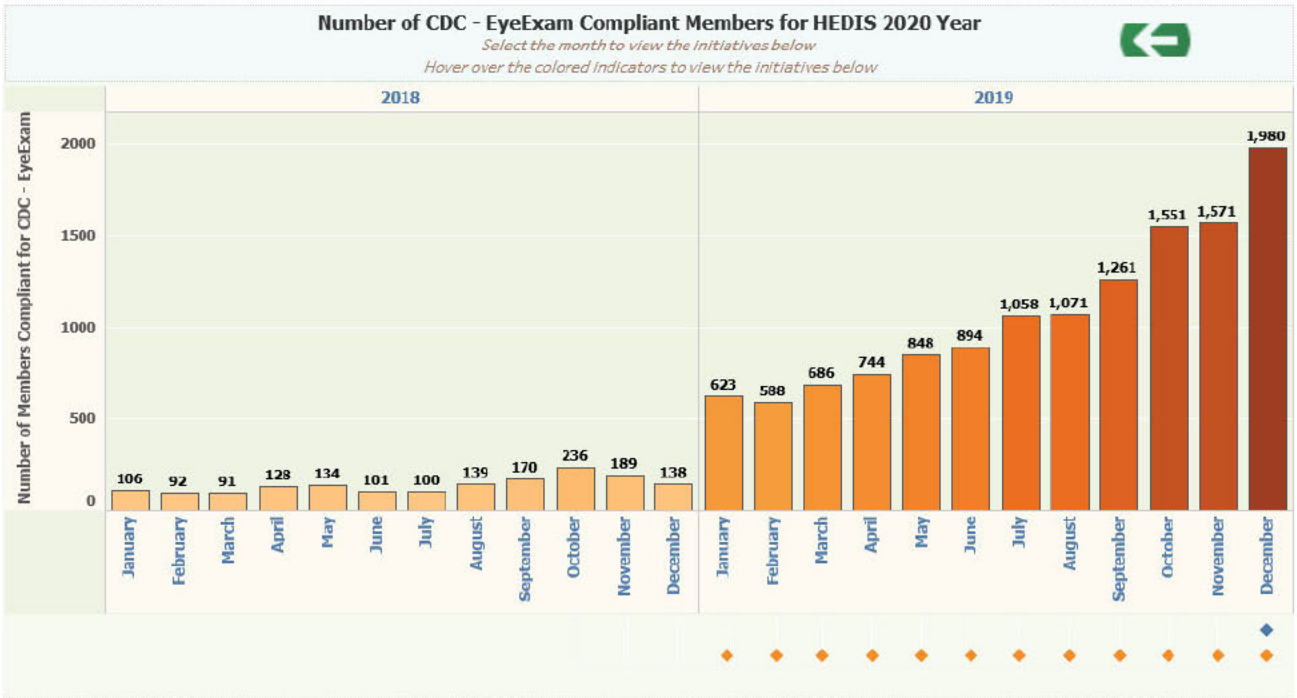
List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description	
A1c IVR campaign	11/1/2019	11/24/2019	29525 members	Outreach to diabetic members via robo calls and encourage them to see their provider	◆
Diabetes Health Coaching	12/1/2019	12/31/2019	990 members	Health Coach Care Plan outreach for Diabetes. Health Coaching services.	◆
Member Incentive	1/1/2019	12/31/2019	15196 members	Targeted members who were due for a HbA1c test to receive a $25 gift card	◆

CDC Table 4-Eye Exam Compliant Members for HEDIS 2020

The table below shows the Eye Exam initiatives for the HEDIS 2020 reporting year. It is split into two sections:

- The 2018 measurement year section contains the number of members that had a negative retinal or dilated eye exam (negative for retinopathy) which would count towards HEDIS 2020 reporting year.
- The 2019 measurement year section contains the numbers of members who had a diabetic retinal eye exam due to a date of service in 2019. The data shows a gradual increase month to month from January 2019 to December 2019. The data shows some increases month to month even more so for June 2019 to October 2019. A factor that could have contributed to this increase may have been the distribution of the member incentive in June 2019. The deployment of the Diabetes Health Coaching initiative also helped with increasing the figure in December 2019.



List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description	
Diabetes Health Coaching	12/1/2019	12/31/2019	990 members	Health Coach Care Plan outreach for Diabetes. Health Coaching services.	◆
Member Incentive	1/1/2019	12/31/2019	15196 members	Targeted members who were due for a Diabetes Eye Exam to receive a $25 gift card	◆

2019 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. **HbA1c IVR Campaign**
   - A. **Description:** 55,578 eligible members without an HbA1c completed in the HEDIS 2020 Comprehensive Diabetes Care (CDC) HbA1c testing measure and Medicare LOBs alike were contacted through IVR campaign.

CDC Table 6: IVR calls for All LOBs

2019 A1C IVR Campaign				
LOB	**Successful IVR Calls**	**Unsuccessful IVR Calls**	**Total IVR Calls**	**Rate of successful IVR Calls**
Medi-Cal	17001	35101	52102	32.63%
OC	121	148	269	44.98%
OCC	1033	2174	3207	32.21%

B. Analysis

A successful call is defined as a completed call or message left on voicemail. Overall, there was a 32.63% successful IVR call rate for Medi-Cal. OC had a 44.98% successful IVR call rate. OCC had a 32.21% successful IVR call rate. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an HbA1c test with their provider and using statin medication.

C. Barriers

Some barriers include unable to contact member, disconnected phone number, member hung up before the full message was received.

D. Opportunities for Improvement

1. Consider option for text message method for members with mobile cell phone numbers.
2. Increase effort to "clean up" incorrect mobile phone numbers for members.

2. HbA1c and Diabetic Eye Exam Member Incentives

A. Description

Although the diabetes HbA1c Testing and Eye Exam member incentive have been active since 2016, trend analysis of member incentive only included MY2018–MY2019 data due to unavailability of data beyond MY2018.

1. In August 2018, targeted eligible members that were non-compliant in the HEDIS 2019 CDC HbA1c testing (n=10,891) and CDC Eye Exam (n=15,605) measures were mailed both incentive forms for a $15 gift card.
2. In June 2019, targeted eligible members that were non-compliant in the HEDIS 2020 CDC HbA1c testing (n=15,196) and CDC Eye Exam (n=5466) measures were sent the HbA1c Test and/or diabetic eye exam member incentive forms for a $25 gift card. In addition to the member incentive forms, the members also received information on statin medicine and diabetes health coaching services. Population based on March 2019 data pull.

B. Findings

CDC Table 7: MY2018–MY2019 Direct Mail Member Incentive Medi-Cal

Medi-Cal A1C and Eye Exam Member Incentive Mailings						
Measure	**HEDIS Non-Compliant Members Mailed**		**Incentives Received**		**Response Rate**	
	August 2018	**June 2019**	**2018**	**2019**	**2018**	**2019**
HbA1c Test	10,891	15,196	578	510	5.31%	3.36%
Diabetic Eye Exam	15,605	5,466	629	163	4.03%	2.98%

CDC Table 8: MY2018–MY2019 HbA1c Testing and Eye Exam Member Incentive HEDIS Participation Rates

HbA1c Test Incentive Forms	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Incentive Participation Rate
2018	578	546	9,439	5.78%
2019	510	455	12,643	3.59%
Eye Exam Incentive Forms	**Forms Received**	**HEDIS Qualified**	**HEDIS Denominator**	**HEDIS Incentive Participation Rate**
2018	629	593	13,589	4.36%
2019	163	152	4,714	3.22%

C. Analysis

1. In MY2018, of the 10,891 members who were mailed the HbA1c Test incentive, 9,439 remained in the denominator. Of the 578 submitted HbA1c test incentive forms, 546 remained as HEDIS eligible, yielding a 5.78% response rate of HEDIS eligible submissions.
2. In MY2018, of the 15,605 members who were mailed the Eye Exam incentive, 13,589 remained in the HEDIS denominator. Of the 629 submitted Eye Exam incentive forms, 593 remained as HEDIS eligible, yielding a 4.36% response rate of HEDIS eligible submissions.
3. In MY2019, of the 15,196 who were mailed the HbA1c Test incentive, 12,643 remained in the denominator. Of the 510 submitted HbA1ctest incentive forms, 455 remained as HEDIS eligible, yielding a 3.59% response rate of HEDIS eligible submissions.
4. In MY2019, of the 5,466 members who were mailed the Eye Exam incentive, 4,714 remained in the denominator. Of the 163 submitted Eye Exam incentive forms, 152 remained as HEDIS eligible, yielding a 3.22% response rate of HEDIS eligible submissions.

D. Barriers

1. One of the largest barriers for the Eye Exam incentive program was the stall with VSP contracted vision providers permitting members with diabetes to get an annual diabetic eye exam. Although efforts to correct the contract has permitted diabetic members to get their exam on an annual basis — due to a delay in updating the eligibility file that was sent to VSP with a diabetes identifier — CalOptima members were turned away by VSP when in fact members were eligible for the exam.
2. HbA1c test incentive forms regularly came back with the HbA1c value field empty or it was clear members had filled out the form themselves with a blood sugar value reading instead of an HbA1c test value. In addition, a significant number of providers did not complete the retinopathy exam result on the form, often returning the forms with that field blank.
3. In MY2019, due to a data filtering error, only members missing both exams were mailed the incentives rather than members who were missing either the HbA1c test or eye exam. This error was found after the mailing was completed.
4. The target population was not identifiable until after the denominator was pulled usually in March or April of MY, thus causing a regular delay in mailing the incentives.

E. Opportunities for Improvement

1. To promote the importance of annual diabetic eye exams, regardless of whether the member falls into the HEDIS denominator or not, the diabetes incentive mailings will be mailed to all members identified with a diabetes diagnosis.
2. For greater emphasis of compliance with Diabetes HbA1c Testing and Eye Exam, along with all other incentives, there will be concerted effort for greater promotion and marketing of the diabetes member incentives through the HNs, CCN providers and in the community.

2020 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. Emerging Risk Health Coaching Telephonic Outreach

A. Description

To address emerging risk in a timely fashion, eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test were identified for telephone outreach by a health coach to identify quick solutions for returning the HbA1c levels below 8.0%.

B. Findings

CDC Table 9: 2020 Health Coaching Outreach for All Programs: MC, OC and OCC

Year	Qtr	LOB	Starting Denominator	Members assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessful Outreach	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q1	OCC	4	4	2	0	0	0
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	**Q1**	**Total**	**152**	**147**	**41**	**5**	**1**	**0**
2020	Q2	OC	8	0	0	0	0	0
2020	Q2	OCC	85	8	6	1	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0
2020	**Q2**	**Total**	**824**	**43**	**28**	**2**	**13**	**0**

C. Analysis

In Q1 2020, 147 emerging risk members were assigned for telephonic Health Coaching outreach with 41 successful outreach calls. In Q2 2020, 43 emerging risk members were assigned for telephonic Health Coaching outreach and had 28 successful outreach calls.

D. Barriers

Some barriers encountered during the telephonic outreach include being unable to contact the member, unable to coach the member and member opted out/declined telephonic health coaching. In addition, Health Coaches involved in this outreach discovered that the common barriers for members would be homelessness, very limited in terms of food and housing

options and limited transportation/access to care. Another barrier is that health coaches do not get all the questions answered, resulting in incomplete assessments. Health coaches were reminded to try and complete all questions to be able to close out assessments.

E. Opportunities for Improvement

1. Consider outreaching in the next year to members that declined.
2. Stagger the different call attempts at different times to see if member could be reached.
3. Connect homeless members to available homelessness services.
4. Increase awareness of available transportation services to eligible members.

Additional Targeted Diabetes Activities 2020:

- IVR campaign with HbA1c testing and statin medicine messaging for diabetics ran in July 2020 after a deliberate pause due to COVID-19 risk concerns raised by HNs.
- In August, a direct mailing of diabetic eye exam and HbA1c testing member incentives were sent to members who were still outstanding for an annual exam or test. The mailing also contained information on diabetes medication adherence and had a flier for information about the Diabetes Management Health Coaching services. The mailing was originally scheduled for May 2020, however due to the COVID-19 surges, the mailing was delayed and then adjusted to include information about taking precautions when scheduling diabetic exams or care, and for members to discuss the best care plan according to their specific needs.
- Medi-Cal and OCC member newsletter article on the importance of diabetic yearly eye exams, and statin use after a heart attack.
- Collaboration with various HNs on promoting incentive via their call campaign outreach efforts.
- Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
- Ongoing outreach calls to emerging risk population of diabetics who were well controlled, but now have an HbA1c between ≥8.0% and ≤9.0%.
- Ongoing provider fax reports of diabetic members NOT on a statin.
- Ongoing SPD quarterly mailings to educate members with diabetes NOT on a statin on the benefits of statin-use in preventing cardiovascular risk and the importance of having the discussion with their provider.
- Social media message in November 2020 emphasizing the increased for heart disease with diabetes, encouraging members to talk to their doctor about whether a statin may be right for them.

Barriers

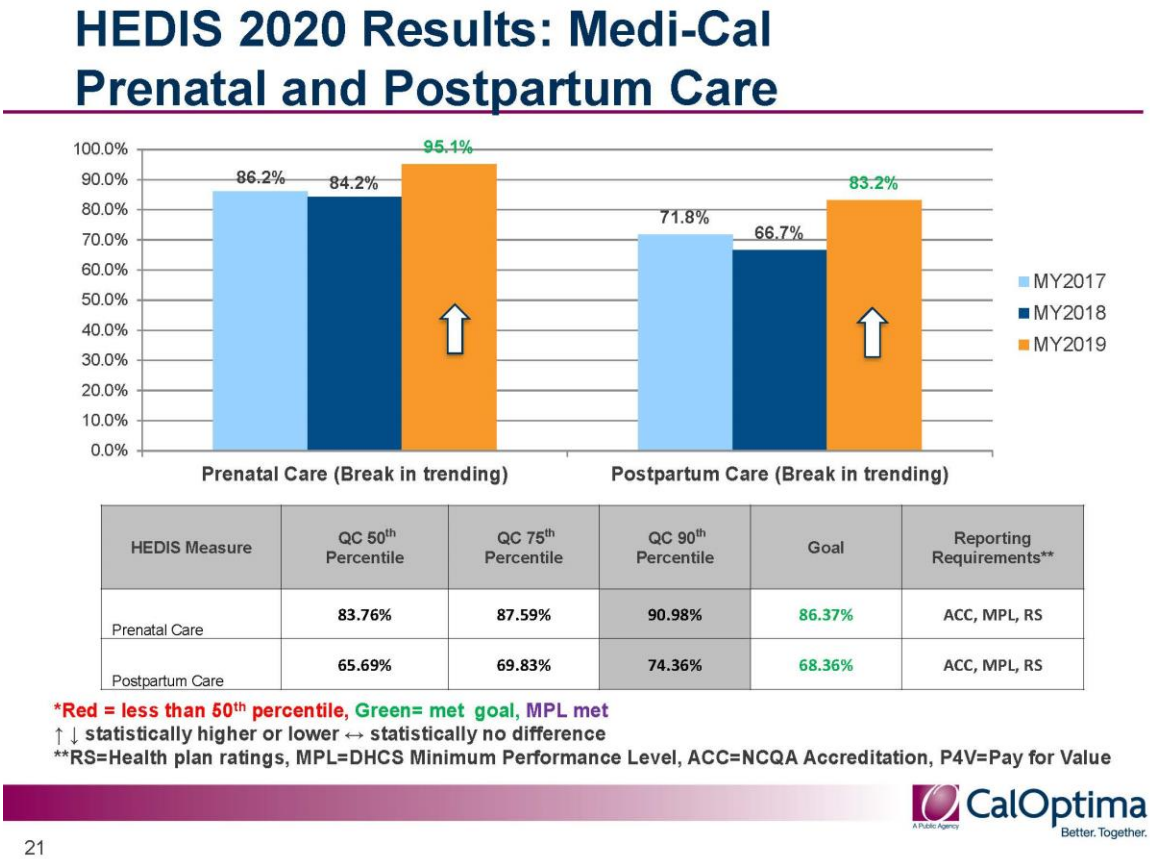
- Members confusion about their benefits related to eye exams. Members who are diabetic are covered to see a vision specialist once every 12 months, but this may not have been communicated clearly to members. CalOptima obtained approval for members to get the service every 12 months with one vendor but this was not translated into the vendor's daily operations for identifying eligible members with diabetes.
- Sharing information between specialists and PCPs sometimes does not occur, thus the PCP may not be aware of previous diabetic eye exam results or the need for an annual diabetic eye exam.
- Limitations in obtaining lab and test data from electronic health records as well as from non-contracted lab vendors.
- Reconciliation of provider data with CalOptima, as some providers use point of care and are not submitting through normal channels.
- Members are not aware of the increased risk of cardiovascular complications with diabetes.

Opportunities for Improvement

- Promote more widely the $25 member incentive program for completion of diabetic eye exams and HbA1c testing to providers through various provider communication modes such as fax blasts, provider portal, HN and provider meetings and through provider relations representatives.
- Explore Office Ally and obtaining electronic health records to improve lab data and access to diabetes medical records.
- Continue targeted call campaign and health coaching intervention for CDC identified members at risk.
- Update VSP eligibility file identification to ensure barrier is removed for annual eye exam for members with diabetes.
- Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
- Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
- Newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Prenatal and Postpartum Care (PPC)

Table 1: PPC HEDIS Rates MY 2017–2019



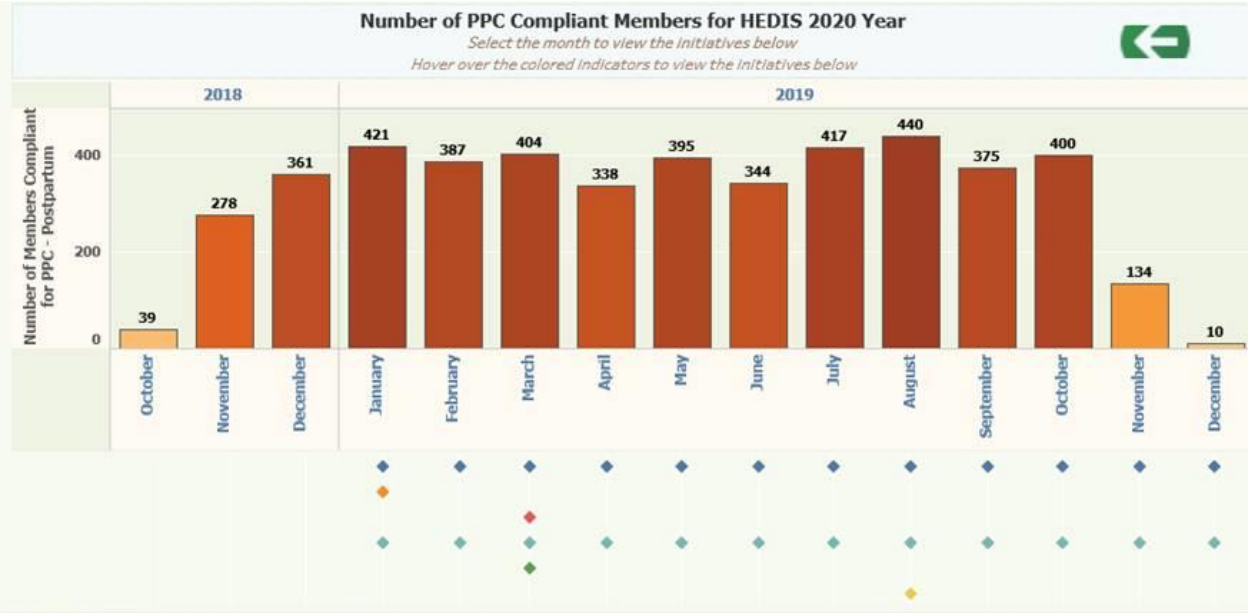
HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.76%	87.59%	90.98%	86.37%	ACC, MPL, RS
Postpartum Care	65.69%	69.83%	74.36%	68.36%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

The table above shows a trend analysis for Medi-Cal PPC measure for MY 2017–2019. The rates showed a significant increase from 2018–2019 from the 75th into the 90th percentile for Prenatal Care and from the 50th into the 90th percentile for Postpartum Care. However, it should be noted that this measure had a significant specification change which resulted in most plans nationally seeing a rise in their rates. (Break in trending on the graph above noted for this reason.)

Prenatal and Postpartum Care (PPC) met the 90th percentile, exceeding the MPL.

PPC Table 2: PPC Compliant Members in HEDIS 2020 MY2019



Note:PPC HEDIS 2020 (MY 2019) includes delivery of live births on or between 10/08/2018 and 10/07/2019. PPC HEDIS measure specifications changed from HEDIS 2019 to HEDIS 2020. Postpartum visit date expanded from between 21 and 56 days to between 7 and 84 days.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	1/1/2019	12/31/2019	2008 members	New Bright Steps program; program for moms and babies. Program includes discussing benefits of postpartum provider follow-up and incentive form during program calls.
Bright Steps Promotion at Breastfreeding Conference	1/29/2019	1/31/2019	N/A	Attended the Breastfeeding conference and tabled for Bright Steps program promotion.
Member Outreach Presentation at CBO	3/1/2019	3/31/2019	N/A	Member presentation (4 total) at Fristers, a CBO that provides service to teen and young adult moms.
Postpartum Checkup Member Incentive Program	1/1/2019	6/30/2019	24 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
	7/1/2019	12/31/2019	161 members	$50 target gift card for completed postpartum visit 3-8 weeks after delivery.
Spring Medi-Cal Newsletter	3/15/2019	3/22/2019	449967* All MC members	2-page spread about Bright Steps program.
Summer/Fall Medi-Cal Newsletter	8/26/2019	8/28/2019	445214* All MC members	Bight Steps program mentioned in newsletter.

PPC Table 2 data represents all Medi-Cal members with live births between 10/08/2018 and 10/07/2019 that met the continuous enrollment criteria under the HEDIS specifications.

2019 Prenatal and Postpartum Initiatives: Medi-Cal

1. Bright Steps Program (BSP)

A. Description

The Bright Steps Program was launched in September 2018 after MOMS perinatal services ended on August 31, 2018. BSP was offered through December 31, 2018 and successfully outreached to 490 members. Not all these members were part of the HEDIS denominator. In 2019, BSP outreached to 2,008 members. This includes members who are not part of the HEDIS denominator. HEDIS Administrative Data is not reflective of full BSP Outreach efforts. Of those, 631 members in the HEDIS denominator participated in BSP. These members met HEDIS parameters related to live birth timeline and continuous enrollment.

B. Findings

PPC Table 6. BSP Participants — MY2018 and MY2019

HEDIS MY	BSP Participation **Includes Members Non-Compliant with PPC Measure**	HEDIS Denominator	BSP Participation Rate
2018	38	**6965**	<1%
2019	631	**6628**	9.52%

PPC Table 7. PPC Compliance Among Bright Steps Participants

HEDIS MY 2019			
Variables	**Total**	**Denominator (BSP Participants)**	**Rate**
BSP participants compliant with PPC HEDIS measure	473	631	473/631 (74.96%)
BSP participants not compliant with PPC HEDIS measure	158	631	158/631 (25.04%)

C. Analysis

PPC compliance was assessed among all BSP participants.

1. In MY2018, less than 1% of members eligible to participate in BSP participated, but it is not reflective of the program's impact. Low participation rates were due to the timeline of the BSP program launch after perinatal services with MOMs stopped on 8/31/2018. And 63.16% of BSP participants were compliant with the PPC HEDIS measure.
2. In MY2019, 74.96% of BSP participants were compliant with the PPC HEDIS measure. This suggests that BSP participation supports its participants in being compliant with the PPC HEDIS measure.

D. Barriers:

1. Bright Steps outreach may only engage portions of the HEDIS denominator. More widespread outreach may capture a larger portion of the eligible population.
2. BSP outreach is triggered by a pregnancy notification report, thus any failure to notify CalOptima of a pregnancy results in a missed opportunity to reach out to members and offer BSP to support their pregnancy.
3. Members may continue to be unaware of the availability of the BSP and/or the PCIP and are not taking advantage of it.
4. PCIP participation remains low among those that are compliant with the PPC HEDIS measure and complete their postpartum visit within the recommended timeframe. Members continue to be unaware of the availability of the PCIP or may be aware of it and are not taking advantage of it.
5. Comparisons between MY2018 and MY2019 PCIP participation cannot be trended due to the change in value of the health reward that went from $25 to $50.
6. PCIP needs more time to trend MY2020 results to identify its impact of PCIP on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. BSP is still in its early stages. Continue to offer BSP and find ways to augment program participation, such as increasing the accurate submission of PNRs. Continuing BSP will not only continue to provide essential services to mom and baby, but it will allow for trends to assess its impact.
2. Continue promotion efforts of BSP and PCIP among HNs, providers and community organizations.
3. Continue to offer PCIP to BSP participants. It is too soon to trend its impact on PPC HEDIS measure compliance. However, the incentive may also bring about other benefits to mom and their newborn such as financial support during a time that is typically characterized by multiple expenditures.

2. Postpartum Checkup Member Incentive MY2018–2019 6/22/2018–11/2/2018

A. Description

In MY2018, 1,010 eligible pregnant members were identified and mailed postpartum packets containing the PPC member incentive which encouraged members to complete their postpartum visit. These mailings occurred from 6/22/2018 through 11/2/2018. In an internal transition of responsibilities, these postpartum packets were replaced with BSP packets and were made available to members upon request. Mailings of packets were intermittent after November 2018 while the BSP was being resourced and staffed. Processes became more standardized by Q1 2019. In MY2019, 2,008 members were outreached to offer BSP and participating members were mailed BSP packets that contained the postpartum check member incentive.

B. Findings

PPC Table 3. Postpartum Checkup Incentive Submissions MY2018 and MY2019
The tables below show the participation rates and impact on the PPC HEDIS measure across MY2018–2019.

HEDIS MY	PPC Incentive Submissions	PPC Measure Denominator (Total births)	Response Rate
2018	71	6965	**(71/ 6965) 1.02%**
2019	115	6628	**(115/6628) 1.74%**

PPC Table 4: PPC Compliant Members in HEDIS 2019 MY2018

Note: PPC HEDIS 2019 (MY 2018) includes delivery of live births on or between 11/06/2017 and 11/05/2018. Postpartum visit date can occur anytime between 21 and 56 days after delivery.

List of Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Bright Steps Program	10/1/2018	12/31/2018	490 members	Launch of new Bright Steps program.
MOMS Perinatal Services	Started before 2017	8/31/2018	N/A	MOMs is contracted to provide perinatal services to our Medi-Cal members.
Postpartum Checkup Member Incentive Program	1/1/2018	12/31/2018	82 members	$25 target gift card for completing a postpartum visit 3-8 weeks after delivery.
Postpartum Packet Mailing	6/22/2018	11/2/2018	1010 members	Mailed PPC incentive flier with MEM7 Postpartum Packets
Provider Communication Promoting Bright Steps	10/25/2018	10/25/2018	62 CPSP Providers; 434 Non CPSP Providers	Fax blast to OB providers regarding the launch of Bright Steps, pregnancy notification reports and requirements for CPSP providers.

PPC Table 5. PPC Incentive Submissions by Compliant Members MY2018 and MY2019

HEDIS MY	Members in Compliance with PPC Measure that Participated in PPC Incentive	Total Members in Compliance with PPC Measure	PPC Incentives Submitted By Members Compliant with PPC Measure
2018	56	3954	**(56/3954) 1.41%**
2019	102	4743	**(102/4743) 2.15%**

C. Analysis

1. In MY2019, 71.56% of members were complaint with the PPC measure and received a postpartum visit between 7 and 84 days after delivery. This represents a 14.79% increase in compliance from MY2018. The increase in PPC measure compliance rate is likely due to the expansion of the postpartum measure visit date from between 21 and 56 days in MY2018 to between 7 and 84 days in MY2019.
2. MY2018 PCIP participation rates were low and did not seem to support an increase in PCC measure compliance. While there is an increase in the postpartum checkup incentive program (PCIP) participation in 2019, especially after the health reward value increased

from $25 to $50 in July 2019, there is no suggestion that the increased value of the health reward was the sole reason behind the increased PPC HEDIS measure compliance.

D. Barriers

1. A one-time mailing is not sufficient to alert members of the key importance of postpartum checkup. Low participation rate could be attributed to lack of incentive awareness.
2. In 2019, the date ranges on the incentive form remained at getting a postpartum check at 3–8 weeks postpartum. The form was not updated until February 2020 with the updated date range of 1–12 weeks postpartum.

E. Opportunities for Improvement

1. Continue to promote Bright Steps Program and brand recognition as well as adding of staff.
2. Utilize PPC incentive in a more comprehensive effort to target new mothers to go in for their postpartum check.
3. Continue to incorporate postpartum checkup incentive forms into all Bright Steps maternal packets
4. Implement standard work for trained Bright Steps personal care coordinators to inform members and help schedule postpartum check exams and to take advantage of the incentive offer.
5. Implement a more robust promotion strategy of PPC measure through publicizing the incentive program linked with the Bright Steps program and PPC member incentive to ensure members are aware of the importance of their postpartum checkup.

Additional PPC Activities in 2019

- Tabled and promoted BSP at Breastfeeding Conference in March 2019.
- Presented BSP at Fristers, a community-based organization that provides services to teen and young adult moms.
- PPC incentive program for $25 gift card to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 24 members that participated in the incentive program.
- PCC incentive program revised in July 2019, increased gift card to $50 to Medi-Cal members who complete their postpartum checkup between 3–8 weeks after delivery. It had 160 members participated in incentive program.
- BSP was able to outreach to 2,008 members providing health education, discussing benefits of postpartum provider follow-up and incentive form during program calls.
- Published two-page spread about BSP in Spring 2019 Medi-Cal newsletter discussing the importance of postpartum care.
- Included BSP promotion in Summer 2019 Medi-Cal newsletter.

2020 Prenatal and Postpartum Initiatives: Medi-Cal

- From January 1, 2020–October 15, 2020, the BSP PCCs made 3,061 attempted outreach calls based on PNRs, self-referrals, HN referrals and internal referrals. Of which, 1,792 initial or postpartum assessments were completed for initial or postpartum (PP) assessments which included a BSP packet sent that included a PPC incentive form.
- All members were outreached to and provided verbal education throughout pregnancy/postpartum and/or provided mailed health education materials that included the postpartum incentive form. Of which, 1,100 postpartum members were called to complete a PP assessment and reminded of the PP visit, over 600 completed the calls and received a PP follow-up reminder verbally by BSP staff.

- The PPC incentive form was updated to represent the longer range between 7 and 84 days postpartum, that the checkup allowed.
- Collaborated with engaged HNs with their call campaign outreach efforts and exchanged data.
- Comprehensive Perinatal Services Program, and an overview of CalOptima's BSP. Also, sent obstetrics providers prenatal/postpartum materials and a BSP prenatal and postpartum care poster.
- Provide HCA Women, Infants, and Children (WIC) sites with BSP prenatal and postpartum care poster to hang in WIC waiting rooms.
- Uploaded the PPC incentive form to CalOptima website for increased member access.

Barriers:
- COVID-19 has become a barrier for prenatal and postpartum care among members.
- A significant number of members that have delivered via c-section have been going in for the wound check visit within the first two weeks and not returning for a postpartum visit between days 21–84 days of delivery.
- Lack of mental health and substance use support in Orange County for pregnant and new moms, which ultimately reduces these members attending prenatal and postpartum visits.
- Providers notifying CalOptima of pregnancies through PNRs. Reduced PNRs results in a missed opportunity to support a member's pregnancy through participation in BSP.
- Teen moms have a barrier in obtaining vaccines during pregnancy because they must get them at their PCP and not their OB. Adding an additional visit, may deter members.

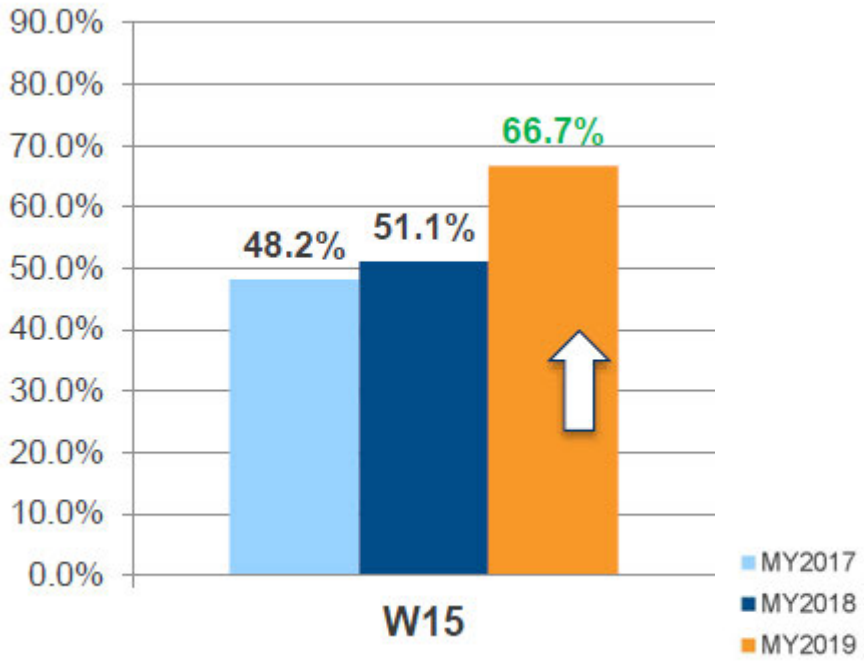
Opportunities for Improvement
- Coordinate promotional campaign to members, providers and community partners for BSP emphasizing the $50 PPC member incentive program.
- Promote CalOptima website and social media platforms with an educational message about women's health and maternal mental health awareness messaging in May 2020.
- Improve collaboration with HNs and CCN providers to promote prenatal and postpartum visits.
- Create a BSP booklet with pregnancy, postpartum and infant information. The booklet will tie in CalOptima benefits and programs.
- Incorporate Adverse Childhood Experiences (ACEs) screening and trauma informed care approach prenatal and postpartum care.

Well-Child Visits in the First 15 Months (W15)

The W15 measure became the top priority initiative in 2019 and 2020, focusing on increasing compliance rates for the W15 measure, which requires the completion of six well-child visits for members from birth to before their 15-month birthday. CalOptima has consistently scored in or below the 50th percentile in 2017 and 2018 and was at risk of not meeting MPL for MCAS requirements which would then lead to potential sanctions and a corrective action plan.

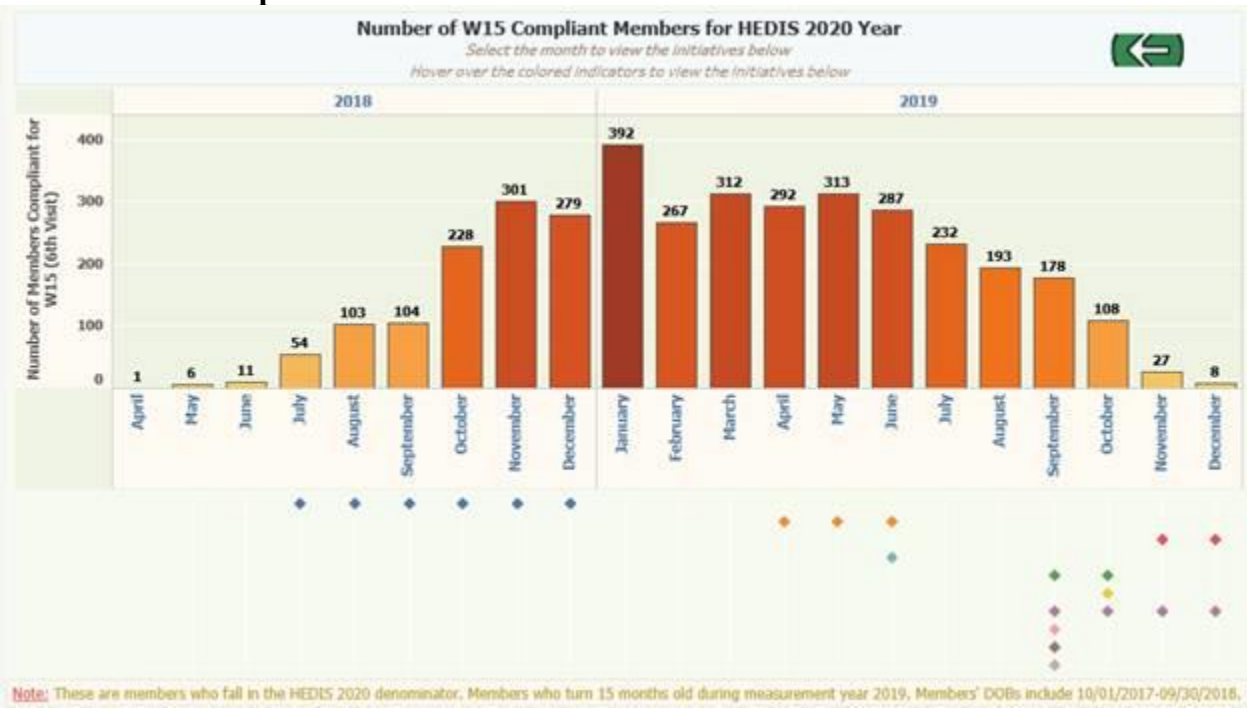
Performance Against Goal:
The table below shows a trend analysis for Medi-Cal W15 rates for MY2017–2019. The rates were consistently below the 50th percentile for two years, however, rates shot above the 50th percentile in MY2019. The W15 measure met the 50th percentile MPL and met goal of 65.83% in MY2019.

W15 Table 1: Number of W15 Compliant Members for HEDIS 2020 Year



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	65.83%	69.83%	73.24%	65.83%	MPL, P4V

W15 Table 2: Compliant Members for HEDIS 2020 Year



W15 Table 2 represents all new compliant (six or more visits by 15 months) members by month between April 2018 and December 2019 (n=3696). These members fall in the HEDIS 2020 W15 denominator (N=7765). W15 HEDIS administrative rate is 47.60%. Note, W15 measures members who turn 15 months in the measurement year, however, members age out at different times

throughout 2019. W15 initiatives began in full force in Quarter 3 and 4 of 2019. There was a spike in members identified as completing six well-child visits in January 2019, n=392.

2019 Well-Child Visit in the First 15 Months Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

To address the consistently low performing W15 measure, a concerted campaign to increase the number of W15 visits within compliant timeframe began in April 2019. High volume offices with members who were non-compliant were provided outreach lists to schedule members for CalOptima Day events focused mainly towards W15 and other pediatric well care visits. Members who attended received a $25 gift card and promotional items. Providers received a check of up to $2,400, depending on their tier.

B. Findings

1. There were 11 HNs/provider offices that participated, which yielded 18 child and adolescent events.
2. There were 876 children who participated in CalOptima Days, with 870 were CalOptima Medi-Cal members.
3. Out of 40 of the 870 CalOptima Medi-Cal members who participated in CalOptima Day Phase 1, fell into the MY2019 W15 HEDIS denominator.
4. Attending CalOptima Day event helped impact 22 member's HEDIS numerator count (e.g. visit counted towards Visit 3, Visit 4, Visit 5).
    - With 7 members that became compliant on the CalOptima Day event.
5. Of which, 22 of these 40 members are compliant for W15 by end of measurement year.

C. Analysis

1. Assumptions: Membership (denominators) for clinics are fluid throughout the measurement year due to members losing eligibility, regaining eligibility—e.g. HEDIS technical specifications has an allowable enrollment gap of 45 days, or being completely terminated.
2. Unable to correlate if attending a CalOptima Day is the reason why a member became compliant for W15 since it requires a series of well-care visits but can assume it contributed to a visit numerator hit.
3. Based on claims and encounters received through August 2019, 35 W15 members had a DOS on CalOptima Event Date. Of those, the data showed the member's visit complied with W15 and/or CIS measure. Even though the events did not outreach to many W15 members, the ones who did come in impacted the following measures:
    - CIS only: 1 member
    - CIS + W15: 10 members
    - W15 only: 24 members

D. Barriers

1. Scheduling challenges and inconsistencies in information relayed to members for CalOptima Day resulted in member confusion and delay of gift card assignment.
2. Provider offices had limited resources to call the members on the outreach lists, which required offices to reconcile with their internal records for most updated contact information, eligibility, and measure compliance.
3. Exchange of outreach lists and schedules were difficult as some offices did not have an established secure email portal or could not get access to Cisco.

4. Reminder letters required a lot of administrative work and had to be completed in a short timeframe. Letters did not seem to generate a high yield of responses.
5. CalOptima's data is not up to date with claims lag.

E. Opportunities for Improvement

1. Stop offering to send outreach lists to participating PCP offices in the future since CalOptima's data is not up to date with claims lag.
2. Do not send reminder letters to members who are scheduled for CalOptima Days as it is resource intensive with low yield. Provider offices tend to have their own method of appointment reminder (e.g. text or phone call day prior).
3. Establish roles and responsibilities in the planning stages of CalOptima Day to understand who can be contacted for deliverables and who will be available on-site on event day.
4. Focus on a targeted HEDIS measure with a smaller population to increase probability of increase HEDIS rate.
5. Do not provide or promote promotional items.
6. Do not require CalOptima to table the event or sign out gift cards. Remove member incentive all together to eliminate administrative accountability.
7. Discuss with participating offices appropriate coding and best billing practices. Incorporate a requirement for immediate claim and encounter submission as part of the provider incentive.

2. W15-Only CalOptima Days 11/19/2019–12/19/2019

A. Description

In an effort to refocus on scheduling only W15 visits and move away from other pediatric or piloted adult well care visits, 4 clinic sites participated in W15-only CalOptima Days in Q4 2019. A total of seven CalOptima Day events occurred, as each site could host more than one event in the same week.

- Strong Kids Medical Group
- Pediatrics & Neonatology
- South Coast Pediatrics
- Friends of Family Health Center

1. Provider offices outreached to any members ages 0–15 months old. Patients had to be a CalOptima Medi-Cal member.
2. Unlike previous CalOptima Days, outreach lists were not provided to the office.
3. Event day schedule lists and final HEDIS 2020 Rates used to evaluate.
4. Provider offices received an incentive for hosting CalOptima Day.
5. No member incentive was provided for this series of CalOptima Days.

B. Findings

1. Only 24 of the 129 members who participated in the W15-Only CalOptima Day fell into the MY2019 W15 HEDIS denominator.
2. Attending W15-only CalOptima Day event helped impact two member's HEDIS numerator count.
3. One member became compliant on the CalOptima Day event.
4. Of which, 11 of these 24 members were compliant for W15 by end of MY.

W15 Table 3: W15 CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed HEDIS Eligible Members
South Coast Pediatrics	66	52	78.79%	44
South Coast Pediatrics	4	3	75.00%	2
South Coast Pediatrics	16	15	93.75%	15
Pediatrics and Neonatology	47	34	72.34%	34
Strong Families Santa Ana	21	14	66.67%	14
Friends of Family (Tustin)	6	4	66.67%	1
Friends of Family (LH)	63	31	49.21%	19

C. Analysis

1. Offices were able to outreach and identify their 0–15 months population without needing CalOptima's administrative help.
2. Average attendance rate was 71.77% which was higher than the CalOptima Days Event in Q2 2019 (67.17%).
3. Final HEDIS 2020 W15 Admin Rate was 47.60% (excluding Kaiser members).
4. Impact to administrative rate: 0.013% (1/7765). Overall, the CalOptima Day Events did not impact the HEDIS population as desired, as a small percentage of those who attended impacted the administrative rate.

D. Barriers

1. In an effort to ease the scheduling process, the offices were able to outreach to *any* Medi-Cal member that falls into the 0–15 months age range, therefore member visits may not have been included toward the W15 HEDIS 2020 rate due to specific eligibility requirements.
2. The CalOptima Day events in Q4 2019 were a year-end effort to improve W15 rate, so all six visits may not have been able to be scheduled and completed before the end of the calendar year.
3. There's inaccuracy in relying on the offices to know which visit in the series of six the member was coming in for.
4. Offices schedule members for the well-child visits at different age increments, not necessarily in compliance to the 6 visits *before* 15 months that HEDIS specifications stipulate.
5. It was difficult to conclude that CalOptima Days made a significant impact on the overall increase in W15 rates versus other simultaneous intervention efforts, including supplemental encounter and data capture, educational campaigns and the member and provider W15 incentives.
6. Total of $8,000 in provider incentives was spent on these CalOptima Days. The return on investment (ROI) was low; the impact on W15 HEDIS rate was 0.013%.
7. CalOptima Days were a good avenue to engage and educate the provider offices on the effort to improve well-child visit rates. The coordination provided an avenue to correct

certain provider office well-child schedules and to provide an exchange of data and a closer look at their data.

8. Future proactive provider engagement regarding data should be pursued considering W15 is a P4V measure and there seemed to be confusion on measure expectations.

E. Opportunities for Improvement

1. Discontinue CalOptima Days due to the significant amount of staff time and resources required to coordinate, execute and follow up with member and provider incentive payouts

3. Health Guide 0–2 Newsletter 06/21/2019

A. Description

Health Guide 0–2 newsletter mail dropped on 06/21/2019 and targeted 10,991 Medi-Cal members ages 0–2 years old and fell into the CIS and W15 denominator, using March 2019 prospective rate (PR) data to filter mailing list. For the evaluation please see the HEDIS 2020 Final Rates.

B. Findings

1. The Health Guide 0–2 newsletter was mailed to 6510 members in the W15 HEDIS denominator .
2. After receiving the mailing, 830 of the 6510 members completed their 6th well-child.
3. By end of MY, 2,848 of the 6510 members were complaint for W15.
4. Participation by 160 of the 6510 members in the W15 4-6 incentive program. Of which 132 of the 160 members were compliant for W15.

C. Analysis

1. Even though 830 members completed their sixth well-child visit and became complaint ***after*** receiving the Health Guide 0–2 mailing, we cannot correlate the mailing as the reason they visited their provider. Members may have had other outreaches/touchpoints. The Health Guide 0–2 mailing occurred midyear in June, before the incentive was launched in September.
2. The newsletter mailing project (including postage) cost $13,714.43. If the mailing was the reason members visited their providers, the cost was approximately $16.52 ($13,714.43/830) per member for each HEDIS hit.

D. Barriers:

1. Health Guide 0–2 newsletter only included member health education regarding well-child visits and vaccinations. No well-child visit incentive form was included.
2. No direct correlation between receipt of the health guide and the child’s visit to the provider.

E. Opportunities for Improvement

1. Make the Health Guide available online and promote the newsletter through other avenues (e.g. Community Connections).
2. Use Health Guides as supplemental education source if members need it.
3. Stop Health Guide mailing.

4. Well-Child Visits 4–6 Member Incentive 09/01/2019–12/31/2019, and Targeted Mailing 09/03/2019

A. Description

Medi-Cal CalOptima members ages 0–15 months are eligible for Well-Child Visits 4–6 incentive if they complete six well-child visits before turning 15 months old. The form must be completed by their provider and faxed in within 60 days of the sixth DOS. The incentive program launched 9/1/2019 and ran through 12/31/2019. An updated incentive form launched 1/1/2020. A targeted mailing was dropped on 09/03/2020 as a concerted effort to reach out to members who were due for W15. Mailing quantity: 1627, based on June provider relations data. The following evaluation is data is from PHM Incentives Database and final HEDIS 2020 rates.

B. Findings

1. The incentive mailing was sent to 1299 W15 members in the denominator.
2. Of which, 821 of these 1299 W15 members were compliant for W15 by end of measurement year.
3. Total incentive forms received: 276
4. Total qualifying for HEDIS (fell in the W15 denominator): 176
5. Actual members compliant for HEDIS: 145

C. Analysis

1. In 2019, of 276 W15 incentive forms received, 176 members were in the W15 measure denominator. The incentive participation rate for the HEDIS 2020 W15 measures was 10.82% (176/1627). Of the 176 submitted forms there were 47 forms (26.74%) had a sixth visit DOS that matched our claims/encounters data that fit all Quality Spectrum Insight (QSI) HEDIS criteria.
2. Of the 1627 members that were targeted, 1299 were in the denominator for the HEDIS 2020 W15 measure. Of those who were mailed the incentive, 666 completed their sixth well-child visit after the mailing.
3. Targeted mailing is not an effective way of getting members to come in for their well-child visits. Only 97 of the 666 members who were W15 compliant and received the outreach mailing, completed their sixth visit and received the incentive. Only 14.56% of members took advantage of the incentive program.

D. Barriers

1. W15 age group is 0–15 months old, however only those turning 15 months old in the measurement year technically falls into the HEDIS measure. So those who are too young, may have completed six visits but are not counted toward W15 denominator until the year after.
2. Since the submissions are not bumped up against claims and encounters, the sixth DOS is not validated. Incentive form was taken at face value.
3. Anecdotal qualitative data showed that in clarification inquiries with various provider offices, certain members were unable to complete their sixth W15 visit before their 15 month birthday, because providers were routinely scheduling members after the member turned 15 months.
4. Unable to correlate if the targeted mailing is the reason member completed the well-child visit series.

E. Opportunities for Improvement

1. This incentive was a pilot program. Will continue as planned and launch Well-Child Visits 1–3 and Well-Child Visits 4–6 incentives.
2. Will bump up submissions against claims and encounters data for 2020 submissions for provider payment. There will be leniency for the member since the provider is attesting to the form.
3. Provide clearer instructions of the measure requirements of when the sixth visit is to be completed.
4. Do not do targeted mailings in the future, rather disseminate incentive program through PCPs.

5. Well-Child Visits 4–6 Provider Incentive Program 09/01/2019–12/31/2019

A. Description

Provider outreach was conducted via fax blast (273 providers), twice. Information was disseminated to HNs through email communications and various network relations meetings and monthly quality meetings. If incentive form was submitted timely and met all incentive criteria, then provider incentive was approved. Did not validate submission (sixth DOS) against claims and encounters data.

B. Findings

1. 49 unique providers participated in the W15 4–6 inventive program pilot
2. Q4 2019 breakdown:
   - Total submissions: 306
   - Total approved: 191
   - Total denied: 115
   - Total incentive: $9,550

W15 Table 4. Well-Child Visits 4–6 Provider Incentive Summary

Incentive Program	Total Submissions	Total Approved	Total Denied	Total Incentive
W15 4–6 Provider	**306**	**191**	**115**	**$9,550**

C. Analysis

1. Approved 191 submissions for provider incentive. However, only 176 members who participated in the incentive program fell into the W15 denominator.
2. An incentive sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 was $9,550. *Note: a few Q1 2020 was accidentally processed along with this batch.*

D. Barriers

1. Incentive forms were taken at face value and DOS were not validated against claims and encounters data.
2. It is probable that more sixth DOS are accurate and claims and encounters were received, but member or visit did not meet all W15 HEDIS specifications to be a numerator hit in QSI.

E. Opportunities for Improvement

1. Revise W15 4–6 incentive form and promote the incentive parameters clearer.

2. Try to touch base with provider offices as incentives are received and processed so there can be education real time to prevent same mistakes moving forward.
3. Bump up submissions against claims and encounters data to validate DOS. Even though incentive parameters were strictly enforced for providers, per the Final HEDIS 2020 rates we learned that most of the incentives submitted were not accurate despite promoting the incentive form as an "attestation."

6. Well-Child W15 Call Campaign 09/13/2019–10/04/2019

A. Description

The W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to promote the Well-Child 4–6 Visits member incentive based on June W15 2019 provider relations data.

B. Findings

1. There were 574 of the 724 members outreached for the Well-Child Call Campaign that fell in the W15 denominator.
2. Of which 471 of the 574 members in the HEDIS denominator were successfully outreached, meaning there was a live phone call with the member or a complete voicemail left regarding well-child visits.

W15 Table 5. Well-Child Call Campaign Summary

	Successful W15 Call	Unsuccessful W15 Call	Total Calls	Rate of Successful Calls
Call Campaign Members Identified	**568**	**156**	**724**	**78.45%**
HEDIS 2020 W15 Denominator	**471**	**103**	**574**	**82.06%**

C. Analysis

1. Had 150 members who were a part of the W15 call campaign fall out of the W15 denominator or was a Kaiser member.
2. Calls to 65.06% (471/724) was successfully outreached to a W15 member.
3. With 361 of the 471 members were compliant for W15 by end of MY.
4. Of which 59 of the 471 members completed their sixth well-child visit after receiving the telephonic outreach. Impact to W15 HEDIS rate was 0.76%. Note, we assume the 59 members completed their sixth visit due to the outreach call.
5. And 12 members who were successfully outreached telephonically, completed their sixth well-child visit after outreach call and submitted an incentive form.

D. Barriers

1. The outreach list was limited to members who were identified as being able to complete six well-child visits, which meets CalOptima's goal of improving our W15 rate.
2. Anecdote from member's parents or guardian:
   - Did not receive the targeted mailing; had to re-mail incentive form.
   - Was not aware they needed to complete six well-child visits before 15th month birthday.
   - Did not know which visits the child had completed.

E. Opportunities for Improvement

1. Recommend a targeted call campaign again in the future to help increase HEDIS rate.
2. Conduct the calls more periodically throughout the year verses one time at the end of the year will minimize members left — who have not aged out — to impact the rate.
3. Prepare a targeted outreach list as a standard work to sustain high successful call rate 82.06%.

7. W15 Root Cause Analysis Survey Incentive 10/10/2019–10/31/2019

A. Methodology/Data

In an effort to identify reasons why the first and second visits were difficult to find data for, an internal Initial Health Assessment (IHA) Core Report was utilized to identify members with a Date of Birth = June 2019 who showed as having completed an initial health visit. The rationale was to identify members who likely did go in for a W15 first or second visit within the first three months of life, but which had not been submitted as a claim or as a well-child-visit encounter administratively. Health educators were provided a survey and script which asked parents where they took their newborns for their first well-child visit post-delivery. The member was offered a $15 gift card for participating in the telephonic survey.

B. Findings

1. Call attempts were made to 94 members.
2. Parent or guardian may have provided more than one well-child visit in the first three months of life.
3. Data is based on QSI prospective rates, well-child visits claims/encounters received and processed as of November 2019.
4. Of which 22 of the 31 members surveyed had a well-child visit claims/encounters in the first there months of life.

C. Analysis

1. There was 70.97% (22/31) of members that had a well-child visit in the first three months of life.
2. There had been 22 newborns with at least one well-child visit in the first three months of life.
    - 29.63% had a well-child visit between birth–2 weeks old
    - 7.41% had a well-child visit at 1 month old
    - 33.33% had a well-child visit at 2 months old
    - 14.81% had a well-child visit at 3 months old

D. Barriers

- Parents did not know the exact date or provider name who completed the well-child visit.
- Parents needed education to differentiate between a sick visit and well-child visit.
- CalOptima does not have data on these well-child visits, even though the calls were made when a child was three months old. There is a data gap.

E. Opportunities for Improvement

- Work with HEDIS team to map out logic to better identify well-child visits administratively.

Additional W15 Activities in 2019

- 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles.

2020 Well-Child Visits Before 15 Months Initiatives: Medi-Cal

1. CHOC Health Alliance (CHA) CalOptima Day 03/04/2020–03/05/2020

A. Methodology/Data

CalOptima Day was planned for Q4 2019 with the other W15 only events, however the event was moved to March 2020. CHOC Health Alliance dedicated two sites for CalOptima Day and focused on members who are due for W15, W34, or AWC.

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments scheduled, 103 attended and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments scheduled, 64 attended and 45 confirmed CalOptima Medi-Cal members.

W15 Table 6. CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed CalOptima Medi-Cal Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. Total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance had a high attendance rate 78.05%–90.35%

D. Barriers

1. Difficulty communicating with CHOC Health Alliance. Had to go through a mediator to get the event going.
2. There was a change in staff which led to delays.
3. Office manager requested to include more members because they were unable to schedule W15 only members. Decision to allow CHA to open their schedule for W15, W34 and AWC members.
4. Post event it was difficult to get the schedule list from the sites to confirm the visits.
5. It was helpful to remove administrative burden on CalOptima to provide outreach lists and send reminder letters. However, without the proper champions on-site it made it difficult.

E. Opportunities for Improvement

1. Discontinue CalOptima Days for the W15 initiative.
2. Encourage designation of a proper champions on-site to continue member outreach.

2. Well-Child Visits 1–3 and 4–6 Member and Provider Incentive 01/01/2020–current

A. Description: Continue the first full year of W15 incentives.

1. Well-Child Visits 1–3: CalOptima Medi-Cal members ages 0–6 months old who complete at least three well-child visits by six months of age qualify for $50 gift card incentive.
2. Well-Child Visits 4-6: CalOptima Medi-Cal members ages 0-15 months old who complete at least six well-child visits before 15 months of age qualify for $50 gift card incentive.
3. Provider was incentivized $50 incentive for every eligible member submission. Well-Child Visit DOS for third and sixth visit will be validated through claims and encounters data.

B. Findings

1. PHM Incentive Database, as of 10/7/20:
   - Well-Child Visits 1–3
     - 1,073 records have been processed
       - 970 records have been approved = $48,500
       - 91 records have been denied
       - 12 records are pending
   - Well-Child Visits 4–6
     - 532 records have been processed
       - 480 records have been approved = $24,000
       - 42 records have been denied
       - 10 records are pending

W15 Table 7. Well-Child Incentive Program Response Rates as on 10/07/20

Incentive Program	HEDIS MY2020 W15 Population	Number of Submissions	Response Rate
W15 1-3	8752	1073	12.26%
W15 4-6	8752	533	6.09%

C. Barriers and Analysis

1. There are more W15 1–3 visit completed submissions than the W15 4–6 visit submissions. The way the incentives were split contributes to a failure to emphasize the need for six visits before 15 months. While the purpose of splitting the W15 incentive in to two parts was to motivate parents at the mid-point to complete W15 4–6 that is not what the preliminary results show. The way the incentives are split, there is no way to determine which visits in the series the dates of service point to. W15 1–3 incentive has approximately 50.33% more submissions than W15 4–6 incentive. The completion of six visits before 15 months is difficult to do due to the lack of continuity with one provider, or non-HEDIS compliant schedule being applied to schedule visits. There is an obvious continued drop off of the fifth and sixth visits.

2. Prospective rates show the rates for W15 1–4 visits are doing better in MY2020 over last year. Visits five and six are behind 9% but are starting to trend in a positive direction. However, a separate evaluation is yet to be completed to see how greater supplemental data and encounters may be the greatest factor, in higher rates.
3. It appears that provider offices are not using the incentive to drive historical non-utilizers to come in for visits, but rather providers are utilizing the incentives to reinforce completed utilization and capitalize on the extra income source for both themselves and members during this unique 2020 year.
4. While most providers seem to follow the Bright Steps well-child visit guidance, discussions with several offices provide evidence that some providers skip the one month old and nine-month-old follow up visit because there is no vaccination required. Offices tend to align their well-child visits with the vaccination schedule. The incentive program has created opportunity to educate participating provider offices on HEDIS expectations and how modifications can be made to well-child visit scheduling to meet measurement standards.
5. Provider office must submit claims and encounters for visit in order for this incentive to be measurable and effective.
6. The W15 incentive in its current format has limitations due to good provider involvement and positive member experience in light of COVID-19. The W15 incentive will continue until a new well care general incentive is discussed and developed to promote overall well care visits especially as the W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.

D. Opportunities for Improvement

1. Sunset the W15 member and provider incentives at the end of 2020 calendar year due to fiscal constraints and depletion of budgeted funds.
2. Preliminary evaluation shows that most member incentives submitted only reflected three visits, and a smaller portion of submissions were for all six visits completed before the 15 month birthday. This suggests that the incentives are not used to motivate utilization as intentioned.
3. The W15 measure is being combined into a Well-Child Visits in the First 30 Months (W30) combined measure, extending the age range from 0–30 months.
4. Notify HNs and providers that the W15 incentive is ending at the end of 2020 calendar year.

Additional W15 Activities in 2020

- **Health Guide 0–2 newsletter and W15 incentive mailing** dropped 07/24/2020 to 8,960 members ages 0–12 months old in English, Spanish and Vietnamese. Members 0–6 months old received W15 1–3 and W15 4–6 incentive form = 3,894. Members 7–12 months old received W15 4–6 incentive form = 5,066
- ***Well-Child Visits During COVID-19 Pandemic*** article in the May Provider Update discussed the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) were prioritized.
- ***2020 CalOptima Member and Provider Incentive Programs*** article in the July Provider Update. Article discussed CalOptima's PHM incentive opportunities, clarified incentive eligibility requirements, and reiterated the W15 member and provider incentive criteria.
- ***Well-Care Visits and Vaccinations During a Pandemic*** in the Orange County Immunization Coalition (OCIC) Summer newsletter.

- **Post Bright Steps Well Baby Follow-Up Call Project in September 2020.** After a mother graduated from the BSP by completing the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level. In the first month, 82 members were identified in the queue for telephone outreach for W15 well-child visits and vaccinations.

Opportunities for Improvement:

- Conduct a formal evaluation of how data gaps can be closed, since the W15 measure is changing into the W30 measure and will be strictly an administrative measure, no longer allowing for medical record review.
- Research on how to gain access to high volume provider offices' EMR system in order to locate member visit information more efficiently whether through Office Ally or other avenues.
- Develop crosswalk to identify potential member visits recorded under mother's CIN.
- Promote well-child visits through Bright Steps prenatal and postpartum calls through Post Bright Steps Well Baby Follow Up Call Project.
- Continue to incentivize well-child visits to providers in the 2021 P4V program, while exploring alternative member health reward options

Adolescent Well-Care Visits (AWC)

The table below shows a trend analysis for Medi-Cal HEDIS AWC for the MY2017–2019. The rates have steadily increased for AWC the past three years. However, a decline is anticipated in the 2020 MY rates due to observed dip in preventive care and well care visits during the COVID-19 pandemic.

AWC Table 1: MY2017–2019 Results: Medi-Cal
The rate for AWC is presented below, AWC met the 50th MPL at 57.0%, but did not meet the goal of 60.34%.

HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Adolescent Well-Care Visits (AWC)	54.26%	62.77%	68.14%	60.34%	MPL, P4V

2019 Adolescent Well-Care Initiatives: Medi-Cal

1. CalOptima Day Phase 1 04/17/2019–06/26/2019

A. Description

In an effort to impact adolescent well care visits, March, April and May 2019 prospective rates were pulled to provide offices with outreach lists to schedule members for CalOptima Day event.

B. Findings

1. A total of 18 CalOptima events focused on adolescent well-care visits. These events were held at 11 different clinic sites throughout Orange County.
2. The events yielded a potential of 625 HEDIS hits across the five pediatric HEDIS measures.
3. Based on the July 2019 prospective rates, 546 members fell into the AWC denominator, which yielded a potential of 373 potential hits for the AWC measure.

AWC Table 1. Measuring AWC rate improvement between July 2018 prospective rate and July 2019 prospective rate for CalOptima Day Participating Provider Offices

PROVIDER OFFICE NAME	AWC Rate Improvement
CHOC Orange Clinic	-4.84%
CLINICA CHOC Para Ninos	-2.66%
Gateway Medical Group*	-11.76%
Pediatrics & Neonatology	3.10%
San Juan Pediatrics	-1.84%
South Coast Pediatrics	-4.99%
StrongKids Medical Group**	5.43%
UCI FHC — Anaheim	3.35%
UCI FHC — Santa Ana	1.92%

* Gateway Medical Group events held at two different sites since members can be seen at either.
** StrongKids Medical Group events held at two different sites since members can be seen at either.

C. Analysis

1. There were 373/625 = 59.68% of the potential HEDIS hits for AWC.
2. On AWC Table 1, the majority of the clinics did not have an AWC rate improvement. However, AWC has the largest population out of the pediatric measures listed above, which allowed for an easier scheduling, but to impact rates it is more difficult.
3. The AWC denominator was too large to impact with limited events such as CalOptima Day. With many resources required, CalOptima Days are not recommended to try and impact the AWC measure. CalOptima Days should be limited to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

D. Barriers

1. Scheduling was challenging for offices to get members in on the same day. No show rates were high.
2. Clinic administration buy-in was important. Clinics with a champion for this event tend to have a better outcome.
3. Learning curves during the planning stage of program.

E. Opportunities for Improvement

1. Stop CalOptima Days to impact the AWC measure.
2. Limit CalOptima Days to a very targeted HEDIS measure with a population (denominator) that is large enough for ease of scheduling but small enough to make a sizable impact on the rate.

2020 Adolescent Well-Care Initiatives: Medi-Cal

1. Annual Well-Care Visits 12–17 (AWC) Member Incentive Program 01/01/2020–current; and Health Guide 13–17 Newsletter Mailing with AWC Incentive Form 05/28/2020

A. Description

An AWC incentive was created to motivate an increase in AWC visits for all eligible Medi-Cal CalOptima members ages 12–17 years old. Requirement was to complete annual well-care visit and submit for a $25 gift card or three movie tickets. The incentive was mailed along with the Health Guide 13–17 newsletter on 05/28/2020 to 74,651 members who were identified as noncompliant for AWC based on February 2020 PR.

B. Findings

As of 10/15/20:

1. 8,301 AWC incentive forms have been processed
   - 6,771 AWC incentive forms have been approved = ~$169,275
   - 541 AWC incentive forms have been denied
   - 989 AWC incentive forms are pending
2. 224 members who submitted an AWC incentive form were a part of the Health Guide 13–17 newsletter and AWC Incentive Form mailing back in 5/28/20.

AWC Table 2. Annual Well Care Visits 12–17 Incentive Response Rate as of 10/15/20

Incentive Program	HEDIS MY2020 AWC Population	Total Incentive Submissions	Response Rate Based on Total AWC Population
AWC	**149,177**	**8,301**	**5.56%**

C. Analysis:

1. An unexpected large surge of incentives were submitted for the AWC incentive. Suspected reasons include the COVID-19 pandemic, in which medical office staff utilized available time to check on AWC visits already completed in 2020, to submit on behalf of members, during a time of financial insecurity. Instead of promoting utilization from historical non-compliant members, the COVID-19 climate ended up boosting incentive submissions due to the unique circumstances described above.
2. Approximately $169,275 was spent on AWC incentive. With a response rate of 5.56% the impact on HEDIS (if all submissions are accurate and claims are submitted correctly) will still remain minor due to the large denominator of 149,177.

3. Response rate for those included in the targeting mailing was 0.30% (224/74651).
4. For MY2020, the AWC HEDIS measure were revised into the Child and Adolescent Well-Care Visits (WCV) measure which combined the W34 and AWC measures and added the ages 7–11 years.

D. Barriers

1. Recommendation for members to complete their annual well-care visit changed in March 2020 due to the COVID-19 pandemic. There was a period where adolescent annual well-care visits were not being scheduled as advised by the CDC. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. June 2020 AWC PR 14.65%, June 2019 AWC PR 18.81%; declined 4.16% compared to last year.
2. Providers did not always use the right CPT code, or did not clearly distinguish between a sports physical exam and a comprehensive well-care visit.
3. Difficult to move the needle with such a large population like AWC.
4. Providers are not using AWC incentive as intended. Where the incentive was designed to motivate and promote future utilization by historical non-compliant members, providers were filling out the incentive form on the member's behalf and submitting it to CalOptima without the member's knowledge and requested that CalOptima not to send denial letters since members were unaware of the incentive.
5. After the mail drop on 05/28/20 to 74,651 members there was an influx of mailed-in incentive forms that were not filled out in its entirety or was filled out incorrectly. Members did not carefully read the instructions requiring an attested visit to be filled in by their provider. The denials and return process created an administrative burden.
6. The sheer volume of the denominator makes the program unstainable due to the drain on budgetary resources, processing burdens and ultimately a minor impact on the rates despite a relatively large volume of submissions. The year was not over and the expenditure was $169,275.

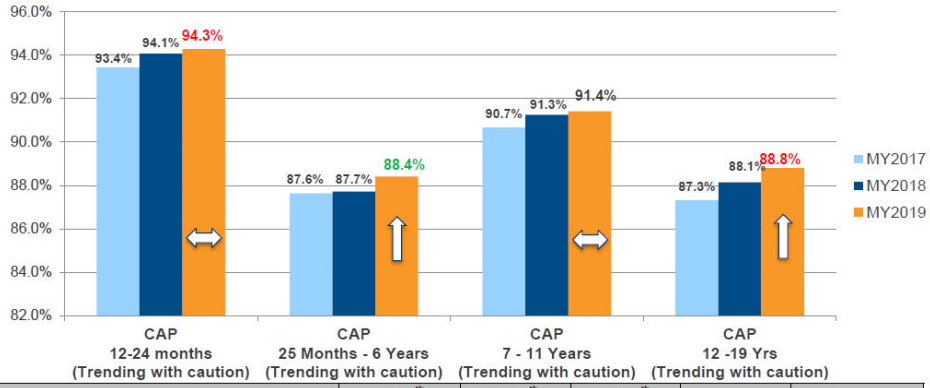
E. Opportunities for Improvement

1. Discontinue AWC incentive when the incentive period ends on 12/31/2020 due to the depletion of budget for member incentives, and an anticipated low impact on such a large numerator.
2. Stop doing targeted AWC mailings as the response rate was low (0.30%).

Children's Access to Primary Care Practitioners (CAP)

Performance Against Goal:

The rate for CAP and its submeasures is presented below. The 12–24 months and 12–19 years submeasures did not meet MPL. The 25 months–6 years and 7–11 years met the 50th percentile MPL. Only, 25 months–6 years CAP submeasure met goal of 87.87%. The 12–19 years submeasure is a P4V measure.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Children's Access to Primary Care Practitioners (CAP)					
12 - 24 Months	95.62%	97.04%	97.82%	95.62%	
25 Months - 6 Years	87.87%	90.32%	92.59%	87.87%	
7 - 11 Years	91.08%	93.41%	95.85%	92.33%	
12 -19 Years	90.21%	92.29%	94.64%	90.21%	P4V

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

2019 Children's Access to Primary Care Practitioners Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
    - Health Guide 0–2 newsletter dropped 06/21/2019, targeted outreach to 10,991 members ages 0–2 years, who were due for CIS and/or W15.
    - Health Guide 3–6 newsletter dropped 07/10/2019, targeted outreached to 45,002 members ages 3–6 years, who were due for W34.
    - Health Guide 7–12 newsletter dropped 11/29/2019, targeted outreach to 14,975 members ages 12 years, who were due for AWC.
- CalOptima Day collaboration with HNs and provider offices hosted a health and wellness event focused on children and adolescents due for W15, W34, AWC, CIS and/or IMA.
    - Q2 2019 events: 11 sites participated, with a total of 18 events, which outreached to 870 members.
    - Q4 2019: three sites participated, which outreached to 129 members.
- Member incentive programs
    - Well-Child 4–6 Visits member incentive launched 09/01/2019. Incentive program awarded members $50 gift card to members ages 0–15 months old who completed at least six well-child visits before child's 15th month birthday. There were 276 total submissions.
        - Targeted Well-Child Visits 4–6 member incentive program mailing dropped 09/03/2019 and outreached to 1627 members who were identified as having an opportunity to complete six well-child visits before 15 months old.
- Provider incentive programs
    - Incentives were sent to 49 providers for participating in the Well-Child 4–6 Visits provider incentive program. Total payout for Q4 2019 is $9,550. Note: a few Q1 2020 was accidentally processed along with this batch.
- The 2019 Medi-Cal newsletter highlighted the *Don't Forget to Vaccinate, Get Shots at No Cost* article discussing the importance of well-care visits, immunization requirements for kindergarten and information on measles. The newsletter was mailed to 449,967 Medi-Cal members.
- Targeted W15 call campaign was conducted between 09/13/2019–10/04/2019 targeting members who have an opportunity to complete six well-child visits before turning 15 months old and to

promote the Well-Child 4–5 visits member incentive. There was 724 members who were outreached telephonically, with 574 successfully (live person or left voicemail).
- The W15 root cause analysis via survey to new mothers asking them where they took their children for their first two well-child visits and when. There were 94 call attempts made and with 31 successful live-person calls. Of that, 27 parents were able to recall a well-child visit date of service and 22 newborns had at least one well-child visit in the first three months of life.
- A fax blast was sent to 273 PCPs of members with outstanding W15 visits that explained the W15 HEDIS measure and the Well-Child 4–6 Visits incentive.

2020 Children's Access to PCP Initiatives: Medi-Cal

- Health Guide newsletter mailings discussed the importance of well-care visits, vaccinations, developmental milestones, healthy eating, care safety and other health education pertaining to the age group.
  - Health Guide 0–2 newsletter dropped 07/24/2020, with targeted outreach to 8,960 Medi-Cal members ages 0–12 months.
  - Health Guide 13–17 newsletter and AWC incentive mail dropped 05/28/2020, with targeted outreach to 74,651 members ages 13–17 years, who were due for AWC.
  - Health Guide 18–21 newsletter mail dropped 05/22/2020, with targeted outreach to 35,799 Medi-Cal members ages 18–21 years.
- IVR Call Campaigns
  - The W15 IVR call campaign slated for Q1 2020 was delayed due to COVID-19. Since Early and Periodic Screening, Diagnostic and Treatment (EPSDT) IVR campaign had similar messaging, W15 IVR was put on hold.
  - AWC IVR campaign slated for Q2 2020 was put on hold due to COVID-19. Messaging does not currently align with best practices during the pandemic.
  - EPSDT IVR campaign slated for Q3 2020 was put on hold. Messaging promoted preventative care to Medi-Cal members ages 0–2 and 3–6 years.
- Communications
  - Included *Well-Child Visits During COVID-19 Pandemic* article in the May Provider Update discussing the importance of continuing well-child visits during the pandemic in accordance with AAP guidelines. Care for newborns and well visit and immunizations of infants and young children (through 24 months of age) are prioritized.
  - Included *2020 CalOptima Member and Provider Incentive Programs* article in the July Provider Update. Article discusses CalOptima's PHM incentive opportunities, clarifies incentive eligibility requirements, and reiterates the W15 member and provider incentive criteria.
  - Promoted the Health Guide 13–17 and Health Guide 18–21 newsletter via Community Connections in July 2020.
  - Launched *Don't Wait—Vaccinate*, immunization campaign and article promoting vaccinations during the pandemic on the CalOptima website, went live 08/21/2020.
  - Included *Well-Care Visits and Vaccinations During a Pandemic* in the Orange County Immunization Coalition Summer newsletter

- **Incentives**
  - Well-Child Visits 1–3 (W15) member incentive program for Medi-Cal members who completed at least 3 well-child visits in the first 6 months of life received a $50 gift card.
  - Well-Child Visits 4–6 (W15) member incentive program for Medi-Cal members who completed at least 6 well-child visits by their 15-month birthday received a $50 gift card.
  - Well-Child Visits 1–3 and Well-Child Visits 4–6 provider incentive of $50 for each completed incentive form for eligible members.

    - Annual Well-Care Visits 12–17 (AWC) member incentive program launched January 2020 for Medi-Cal members who need to complete their annual well-care visit.

- CHOC Health Alliance held CalOptima Day Events 03/04/2020–03/05/2020 which focused on well-care visits for members due for either W15, W34 or AWC. There were 125 CalOptima Medi-Cal members that received service.
- September 2019 launched Post Bright Steps Well Baby Follow-Up Call project. After a mother graduates from BSP and completed the Postpartum Assessment, the Bright Steps team created an activity to follow-up with the baby in either two weeks or when baby was three months old depending on their risk level.

Barriers
- Due to the COVID-19 pandemic, there was a drop in PCP visits starting March 2020. Recommendation for provider offices visits changed. CalOptima's June 2020 Prospective rate reports show a decline when compared to the same time last year. The community was reluctant to go in for their preventive care screenings due to COVID-19.
- Preventative care visits were prioritized for pediatric members 0–2 years old during the pandemic and extended to populations who were due for their vaccinations.
- CAP measure was directly associated with other pediatric measures such as, but not limited to: W15, W34, AWC and WCC. Since other measures have been impacted due to COVID-19, CAP measure shows a decline as well.

Opportunities for Improvement
- The CAP measure were retired by NCQA.
- Focus on other pediatric measures which align with CAP measure parameters.

Overall Evaluation of Quality Initiatives

In 2019 and 2020, quality initiatives were numerous and required many resources. While there were many interventions and activities, not all efforts yielded the maximal return on investment. Some of the more resource-intensive initiatives did have merit. Events such as the CalOptima Days — while staff, time and financially resource-intensive — produced real qualitative benefits including more hands-on engagement with HN quality administrators. The W15 member and provider incentive required overall much more interaction with provider offices, to provide clarification and explanation of the incentive specifications as well as HEDIS requirements. This created opportunity to clarify the well-care visit schedule expectations that would meet the W15 acceptable timeline to satisfy the measure requirements. As a result, some providers changed their appointment schedules in response to that clarification. In addition — especially during the 2020 pandemic period — preliminarily, the engagement in member and provider incentives showed a surge whether it was due to an additional financial need created because of the economic ramifications or whether members and providers became more mindful of health opportunities and also had more time to address them. Furthermore, many provider offices which submitted incentives on behalf of their patients explained that they had more time due to the lull in patient flow, which allowed them to review patient charts and submit incentives on their behalf. We can only assume that member experience has likely significantly improved due to the increased number of rewards mailed to members during the pandemic.

In spite of some of these benefits to some of these more resource involved initiatives, it is clear that the impact on the HEDIS numerator (which closes a gap in member care) for many of these

measures were not impacted in measure to the efforts expended. CalOptima Days required heavy staff, financial and time investment, however, the number of hits that would affect HEDIS were comparably low to the resources invested. Events such as the Mobile Mammography brought high value with member experience to CCN members, however, each event was resource intensive, requiring staff across multiple departments to do outreach calls and make arrangements with the vendor as well as finding the community location that would be the best fit. It is not to say, that the impact on the numerator is the ultimate goal for each initiative, however, there must be a consideration of all factors involved to determine which initiatives to put resources towards in the next work plan year with limited resources.

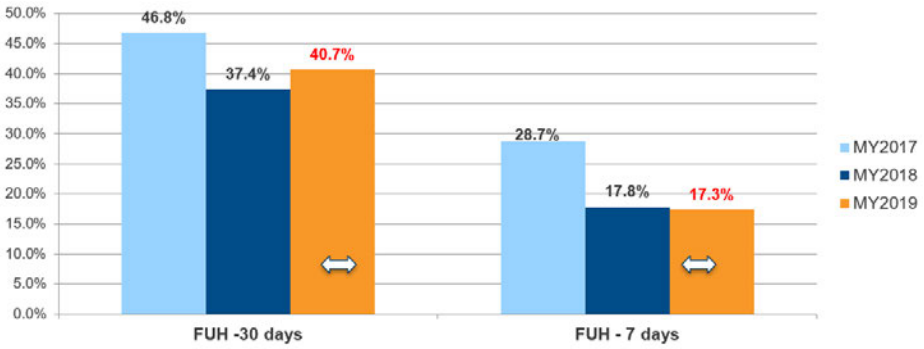
Probably the heaviest lift in 2019 and 2020 were the renovation and addition of new member and provider incentives. In making changes to existing incentives — and adding the W15, the AWC Medi-Cal incentives, and the Colorectal and Breast Cancer Medicare health rewards — the internal effort affected every QI work team from defining the parameters, revising content, program design, graphic design, promotion and marketing to the creation of an ever-evolving internal database to track all incentives efficiently. The largest unexpected burden was the incentive processing which was not anticipated to be as burdensome as it was in execution. The especially large and constant influx of AWC member incentives required the involvement of 12–15 other departmental staff in various capacities to tackle the processing requiring overtime hours. The department is preparing for an incentive RFP to select a member health rewards vendor to open up solutions for a more comprehensive gaps in care overall quality initiative to be developed with a multi-prong communication and member engagement plan.

Overall, in view of the many increases and improvements seen across priority measures, the strongest recommendation is for the focus and efforts be primarily channeled into the improvement of data exchange between CalOptima and all contracted HNs, providers and labs. The exchange of data sparked opportunities for discussion of expectations and sharing of how best to utilize data available at both the provider and health plan level. Through significant efforts to bridge data gaps for W15, connecting the mother’s CIN with her child’s well-care visits and obtaining much needed supplemental data was vital to the improvement of rates.

In the next HEDIS year, many of the measures previously hybrid in nature, will be changing into administrative only data opportunities. The need to address significant gaps and missing data especially in terms of lab data and early well care visits will be vital in helping CalOptima remain performing at or above a MPL for DHCS MCAS measures and for established goals. Access to electronic medical record systems for contracted HNs whether through Office Ally or other contracted means will not only open up CalOptima’s access to much needed encounter data but should also help remedy the lab data gap which is not currently obtained through current limited lab contract data exchanges. Addressing the data gaps will also provide us with accurate and timely information to plan and develop targeted initiatives to the appropriate populations.

Behavioral Health Quality Initiatives

Follow-Up After Hospitalization for Mental Illness (FUH)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	46.16%	59.74%	71.43%	56.00%	CMS, Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	24.79%	34.33%	45.62%	18.20%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Completed Activities in 2020

- In Q1 2020, the Behavioral Health Integration (BHI) management team in partnership with Network Relations visited the top three hospitals with inpatient psychiatric admissions to discuss concurrent review and transition of care management process. The team educated hospital staff about CalOptima's resources and expectations.
- BHI created and implemented a personal care coordinator position to conduct member outreach after member is discharged from hospital to coordinate follow-up appointments. The personal care coordinator also assisted members in securing a follow-up appointment if necessary.
- A report was developed based on data in Guiding Care to track the personal care coordinator outreach activities and post discharge follow up visit in real time. When members did not have a follow up appointment within seven days of discharge, the personal care coordinator outreached to members to identify barriers and secure a visit within 30 days.

A Transition of Care Management (TCM) team was created to building and maintain relationships with hospitals. The team meets with the Behavioral Health (BH) Medical Director weekly to discuss concurrent reviews and internal coordination interventions.

- Credentialed HCA providers who were qualified to provide Medicare covered BH services.

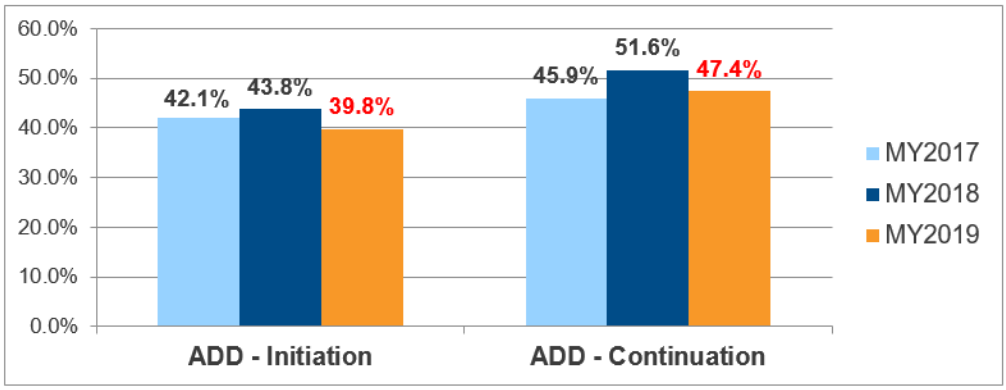
Barriers

- The discharge planning procedure is not standardized among the hospitals that serve our members. In addition, some hospitals lack understanding of the HEDIS requirements for FUH.
- The personal care coordinator was not always able to contact members after they have been discharged from the hospital — particularly if they are homeless or did not provide the hospital with their most current contact information.
- CalOptima is not able to credential some HCA providers due to the board certification requirement. As a result, the County has not been able to bill CalOptima for some of the outpatient psychiatric care provided at county clinics.

Opportunities for Improvement

- The BHI department implemented several virtual care strategies, including eVisits and telehealth, that helped expand access to behavioral health services. Those strategies offer members more options for follow up visit to meet their needs.
- The TCM team will continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment.
- The BHI management team will conduct additional hospital visits to educate discharge planning staff about FUH requirements and address any questions or concerns.

Follow-Up Care for Child ADHD (ADD)



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	43.41%	49.86%	56.57%	48.00%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	55.50%	62.69%	69.15%	55.50%	ACC, RS

*Red = less than 50th percentile, Green= met goal,
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2020

1. BHI created a report to track/trend providers who are non-compliant with this measure. Providers with high frequency of non-compliance were sent a letter to inform them about ADD requirements and the importance of follow-up visits with patients prescribed with ADD medications.
2. The provider education letter was updated to include more details about the requirements and the rationale for follow-up visits.

Existing Barriers

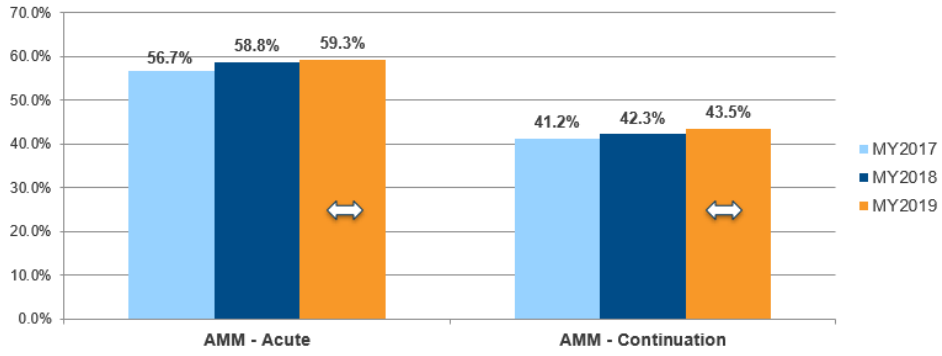
1. The provider letter was mailed to the address on record. We discovered that some of the letters went to an administrative office, which the provider may not be at that location. Also, a few of the letters were returned to CalOptima due to wrong address.
2. We are also aware that providers receive many materials from health plans and other businesses. It is possible that not all providers will read the letter or pay close attention to it; therefore, reducing the overall impact of the intervention.

Opportunities for Improvement

1. The BHI Quality team will continue to send letter to providers who are not meeting the ADD requirements.
2. Providers can schedule an appointment with members who need ADD follow up visit. However, members might have other reasons for not showing up for the appointment. The BH Quality team will explore opportunities to conduct member outreach to identify barriers and assist member with appointment scheduling if necessary.
3. Some of the ADD materials have not been updated for several years. Once updated, the team will distribute the new materials to providers and members as part of the outreach effort.

Antidepressant Medication Management (AMM)

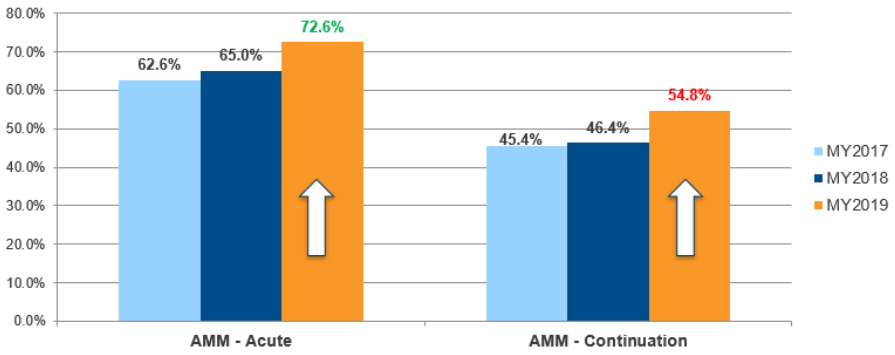
Medi-Cal AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	52.33%	56.41%	65.95%	61.18%	MPL
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	36.51%	40.95%	48.68%	44.82%	ACC, RS, MPL

*Red = less than 50th percentile, Green= met goal, ↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

OCC AMM



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	71.60%	77.19%	83.33%	66.91%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	56.17%	61.31%	67.07%	50.39%	CMS

*Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure
↑ ↓ statistically higher or lower ↔ statistically no difference

Completed Activities in 2020

1. The BHI quality team reviewed and updated educational brochure for members on depression and treatment compliance.
2. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.
2. Members attending doctor appointments via telehealth; therefore, unable to pick up the brochure
3. BHI staff had multiple meetings with Provider Relations (PR) department to discuss the distribution of the brochure. Several challenges were identified including:
    - Temporary closure of providers' offices
    - PR staff not conducting in-person visits

Opportunities for Improvement

1. Offer digital version of the depression brochure to providers so they can share and discuss the material with members during telehealth visit.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers about AMM requirements.
4. Educate members about the importance of depression medication adherence via member newsletters and social media.

Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. DSF requires providers to screen patients ages 12 years and older for clinical depression using standardized depression screening tools AND if positive, provide and document a follow up plan. Since DSF is still a relatively new measure, there is currently no benchmark to evaluate performance. CalOptima had been tracking the measure and conducted improvement activities.

Completed Activities in 2020

1. Depression screening, i.e. PHQ9, was completed as part of CalOptima's health needs assessment (HNA) for Whole-Child Model, complex case management, and care coordination.
2. Successfully loaded PHQ scores recorded in our Medical Management system to HEDIS software.
3. The BHI quality team updated the depression brochure which will be used as outreach material for members and providers.
4. The development of the Living with Depression video posted on CalOptima's website as part of the Health and Wellness Self-Care Guides for members.

Existing Barriers

1. It became apparent after updating the English version of the depression brochure, that a direct translation of the content to other languages may not meet the needs of various ethnic groups.

2. The number of provider educational events dropped significantly due to COVID-19. As a result, there was no opportunity to promote depression screening and treatment in the community.
3. Fewer members are scheduling routine care visits (i.e. well child visit, annual physical exam) resulting in fewer opportunities for providers to conduct depression screenings.

Opportunities for Improvement

1. Develop member information encouraging them to schedule routine/annual visits to increase opportunities for depression screenings.
2. Develop culturally appropriate version of the depression brochure for various ethnic groups.
3. Develop a HEDIS reporting tip sheet to educate providers on the importance of depression screening, available screening tools, and treatment options.
4. Explore ways on how to incorporate tools into CalOptima's internal system to gather data from providers.
5. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

Transition of OC and OCC Behavioral Health

In May 2019, CalOptima's Board of Directors approved transitioning OC and OCC BH services from Magellan to CalOptima. Multiple departments were involved in the implementation including Contracting, Provider Relations, Claims, Customer Services, BHI, Information Services, UM, RAC, and Process Excellence. On January 1, 2020, CalOptima started managing OC and OCC BH services including inpatient psychiatric care, outpatient behavioral health services, and opioid treatment program services. CalOptima was able to directly contract with most of the providers who were seeing our members through Magellan. Providers also had the option to sign a Letter of Agreement (LOA) to continue to see our OC and OCC members if they chose not to contract with CalOptima. The CalOptima BH Line leveraged existing protocols to manage OC/OCC BH calls. Overall, the transition went smoothly with minimal disruption to members care.

Safety of Clinical Care

Opioid Utilization

Opioid Utilization Data 2019–2020 Results

CalOptima Medi-Cal Opioid Analgesic Utilization	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3	% Change 3Q19 to 3Q20
Opioid Analgesic Rxs	38,426	35,927	33,616	31,268	34,530	-10.1%
% Members Utilizing Opioid Analgesic Rxs	1.09%	1.01%	0.99%	0.88%	0.97%	-11.3%
Opioid Analgesic Rxs PMPQ	0.021	0.020	0.019	0.017	0.018	-12.3%
Members Receiving > 80mg Avg MME	604	537	487	456	457	-24.3%

% Utilizing Members Receiving > 80mg Avg MME	3.01%	2.88%	2.78%	2.88%	2.50%	-16.7%
Average Quantity/Rx for Short-Acting Opioid Analgesics	51.7	52.0	52.6	54.6	51.0	-1.3%

CalOptima Opioid Utilization Goals	2019-Q3	2019-Q4	2020-Q1	2020-Q2	2020-Q3
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	13.1	12.3	12.0	11.4	10.9
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	2,639	2,469	2,362	2,179	2,391

CMS Medicare Star Display Measures

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D): Multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care.

- Measure 1: Use of Opioids at High Dosage (OHD): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- Measure 2: Use of Opioids from Multiple Providers (OMP): Members receiving prescriptions for opioids from four or more prescribers AND four or more pharmacies.
- Measure 3: Use of Opioids at High Dosage and from Multiple Providers (OHDMP): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage in Persons without Cancer	OneCare	2%	7%	Equal or Better
Use of Opioids at High Dosage in Persons without Cancer	OCC	5%	7%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids from Multiple Providers	OneCare	0%	0%	Equal or Better

Use of Opioids from Multiple Providers	OCC	1%	0%	Equal or Better

Patient Safety Measure	Plan	2020 Rate (Through Oct.)	MA-PD* Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage and from Multiple Providers	OneCare	0%	0%	Equal or Better
Use of Opioids at High Dosage and from Multiple Providers	OCC	0%	0%	Equal or Better

* *Medicare-Advantage Prescription Drug*

Completed Pharmacy Management Interventions in 2020

Prescriber

1. Quarterly prescriber report card: Intervention provided to providers whose average Milligram Morphine Equivalent (MME) dose per prescription fell above their practice specialty average.
2. Prescriber newsletters:
    - FDA Warning of Respiratory Depression for Gabapentinoids with Concomitant Opioids
    - Opioid Quality Measure Update
3. Monthly Medicare Opioid Overutilization Intervention: Member opioid and benzodiazepine medication list faxed to most recent prescriber of members who meet CMS Opioid Monitoring System (OMS) Criteria.

Pharmacy

1. Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection (overridable by the pharmacist) and exceeding 400mg will trigger a hard rejection (authorization required).
2. Point of service soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

Member

1. Retrospective identification of members meeting criteria for opioid overutilization for Medical Director Review and referral to Compliance, QI or Case Management.
2. Pharmacy Home Program Policy: Members filling prescriptions at four or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
3. Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the members filling controlled substance prescriptions from four or more prescribers in a two month period are restricted to designated prescribers.

Formulary

Medi-Cal

1. Point-of-sale (POS) pharmacy edits triggering a soft rejection for opioid pharmacy claims attempted to be filled within 30 calendar days of a fill for buprenorphine-containing products.
2. Require prior authorization for new starts for methadone doses above 30mg/day.
3. Require prior authorization for new starts for all long-acting opioids.
4. Stricter quantity limits for short-acting opioid analgesics.
5. Concurrent use of opioids and opioid potentiators (such as benzodiazepines or gabapentinoids) formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate National Council for Prescription Drug Programs (NCPDP) codes upon review of drug therapy.

Medicare

1. Hard safety edit to limit initial opioid prescription fills to no more than a seven-day supply.
2. Pharmacist-driven care-coordination formulary safety edit for duplicative long-acting opioid therapy (excluding buprenorphine) with a prescriber count of at least two prescribers that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

3. Pharmacist-driven opioid care coordination formulary safety edit would trigger when a member's cumulative MME per day across all opioid prescriptions reaches or exceeds 90 MME.
4. Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Existing Barriers

1. Lack of timely data from DHCS for Medication Assisted Therapy (MAT) medication carve out claims for Medi-Cal members.
2. No access to data for medications dispensed by Opioid Treatment Programs (OTP).

New Opioid Interventions Completed in 2020

1. Effective October 1, 2019, CalOptima's Medi-Cal DUR program complies with section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS: opioid pharmacy claims for members shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/day without prior authorization.
2. Promote Medication Assisted Therapy (MAT): The use of FDA-approved medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
3. Contract with OTP for Medicare members effective January 1, 2020.

In 2021, the Medi-Cal outpatient pharmacy benefit will be carved out to the state. There are no planned interventions at this time.

Post-Acute Infection Prevention Quality Incentive (PIPQI)

PIPQI is a CalOptima quality initiative program shown to reduce antibiotic-resistant bacteria in hospitals and nursing homes. Participating nursing facilities utilize chlorhexidine (CHG) bath soap for all baths and showers and Iodophor nasal swabs bi-weekly. Currently, 26 nursing facilities participate in PIPQI. CalOptima nurses monitor compliance with CHG and nasal swab usage, Hospital Acquired Infection (HAI) scores, and hospital admissions/readmissions due to infections.

COVID-19 presents the following barriers:

- Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.
- High turnover rates in facilities creates a need for constant PIPQI training.
- Due to COVID-19, CalOptima nurses are not allowed to conduct on-site visits for monitoring or training of facility staff.

CalOptima nurses began monitoring compliance with PIPQI via telephone in March 2020, conducting phone consultations and training. One training video per month is reviewed with all participating nursing facilities. Quality performance measures will be monitored in 2021. PIPQI will be made available to additional facilities per request of facility in 2021. Consultation and training will continue via telephone and webinar until CalOptima nurses can resume on-site visits to nursing facilities.

Additionally, CalOptima partnered with HCA and University of California, Irvine (UCI) to implement the OC Nursing Home COVID-19 Infection Prevention Training Program. Aimed at keeping patients, staff and families as safe as possible during the pandemic by preventing virus spread. Program includes intense in-person training of 12 CalOptima contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima OC contracted nursing facilities.

Goals:

- Outfit OC nursing homes to prevent COVID-19 as soon as possible, but especially in time for fall surge.
- Provide expertise on infection prevention for COVID-19/SARS-CoV-2.
- Provide guidance, protocols for preventing spread of COVID-19.
- Support training on how to stock and use protective gear.
- Develop high compliance processes for protection of staff and residents.

Program was implemented in June 2020 and will run through May 2021. On average, approximately 60 people attend the webinars from approximately 20 nursing facilities. Training materials can be found at uci.org/stopcovid

2019–2020 Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects for 2019–2020 by each improvement project type.

QIPs: OCC Population and NCQA Patient Safety Standard – Medi-Cal

1. Improving Statins Use for Patients with Diabetes (SPD) 2019–2020

The improving statin use for patients with diabetes mailing intervention targets all three LOBs; Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Patient Safety standard. OCC results will be reported to CMS as part of a QIP. There is no QIP requirement for the OneCare population however CalOptima chose to still include this small population as part of the SPD intervention.

Goal
To increase statin use among members with diabetes by 5%.

Target Population
All CalOptima members who are diagnosed with diabetes.

Interventions
A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. An SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care providers about whether a statin is right for them.

Activities
Quarterly mailings and the IVR messaging campaign promoting the discussion with their providers have been put into place to encourage members to consider the potential benefits of preventing cardiovascular complications.

Mailing Summary
Program implemented in Quarter 4, 2019. Data collection is in ongoing for all three LOBs.

SPD Member Quarterly Mailings						
	Q1 2020			Q2 2020		
LOB	Member Count	Members Eligible Sent	Members Received Intervention	Member Count	Members Eligible Sent	Members Received Intervention
OneCare	87	40	32	61	8	5
OCC	761	276	146	630	125	46
Medi-Cal	6150	2334	1006	5320	1007	278
Total	6998	2650	1184	6011	1140	329

2019 Interactive Voice Recording (IVR) A1c and Statin Use Campaign				
Disposition	Medi-Cal	OneCare	OCC	Grand Total
Successful IVR call	17001	121	1033	18155
Unsuccessful IVR call	35101	148	2174	37423

Overall, we had a 32.67% successful IVR call rate across all three LOBs. Members were contacted telephonically via robocall with a message emphasizing the importance of scheduling an A1C test and promoting the discussion of statin use with their health care providers to reduce cardiovascular complications.

Performance Improvement Projects (PIPs)

1. **OCC PIP: Members with Individualized Care Plan Completed/Members with Documented Discussions of Care Goals 2018–2019 Completed April 2020**

Goals

1. CA 1.5 – Members with an Individualized Care Plan Completed
   Year 1 Goal: High Risk: 48.89%; Low Risk: 38.81%
   Year 2 Goal: High Risk: 52.09%; Low Risk: 41.06%

2. CA 1.6 – Members with Documented Discussions of Care Goals
   Year 1 Goal: 77.91%
   Year 2 Goal: 81.57%

Interventions

1. Change language with Health Risk Assessment (implemented 1/3/18)
2. Initiate Initial Care Plan (ICP) discussion goals at the first contact with member

Summary of Results

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (56.45%)
Measurement Year Goal	52.09%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	High Risk (B/A) Quarter 1: (2019) 53.23% (PDSA cycle 4) Quarter 2: (2019) 54.57% (PDSA cycle 5) Quarter 3: (2019) 55.68% Quarter 4: (2019) 56.45%
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	73.48%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	Low Risk (D/C) Quarter 1: (2019) 41.87% Quarter 2: (2019) 43.03% Quarter 3: (2019) 43.70% Quarter 4: (2019) 44.45%
Study Indicator 3	
Study Indicator 3 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	81.57%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 3) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 4) Quarter 3: 07/01/2019 to 09/30/2019 (PDSA cycle 5) Quarter 4: 10/01/2019 to 12/31/2019

Results	Quarter 1: (2019) 93.01% (PDSA cycle 3) Quarter 2: (2019) 90.21% (PDSA cycle 4) Quarter 3: (2019) 91.02% (PDSA cycle 5) Quarter 4: (2019) 92.19% Cumulative Rate (up to end of each cycle/quarter): 1/1/18–3/31/19: 93.01% 1/1/18–6/30/19: 91.55%

For study indicators 1 and 2, changes made to our data collection process in response to regulatory guidance to only count care plans that had proof of member involvement resulted in a change to our data collection process. Our prior process did not have a positive review question that addressed member involvement. When we made the change, it allowed us to collect data specifically aimed at that question for each quarter going forward. However, since this is a cumulative measure, and the target criteria have been modified, when we applied the same logic, we lost the ability to count many care plans that were created prior to the question being implemented.

The CA 1.5 High-Risk rate improved from 52.09% in 2018 to 56.45% in 2019 for an increase of 4.36 percentage points. The 2019 rate of 56.45% was 7.56 percentage points higher than the goal rate of 48.89%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator Fisher's exact test was not performed, but Chi-Square without Yates' correction was used instead (Chi-Squared equals 20.804 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statistically significant outcome.

The CA 1.5 Low-Risk rate improved from 41.06% in 2018 to 44.45% in 2019 for an increase of 3.39 percentage points. The 2019 rate of 44.45% was 5.64 percentage points higher than the goal rate of 38.81%. This showed sustained and increasing improvement. Because of the large numbers in the numerator and denominator, the Fisher's exact test was not performed but Chi-Squared without Yates' correction was used instead (Chi-Squared equals 1516.833 with 1 degrees of freedom). The test's two tailed p-value was less than 0.0001 and yielded an extremely statically significant outcome.

For study indicator 3, results continue to show strong improvement, with Q3 results indicating that 91.02% of members had discussions of care goals. In Q4, we achieved the rate of 92.19%, which exceeds our goal of 81.57%.This intervention is proving to be effective and will be continued.

CalOptima has satisfied all requirements for the OCC ICP PIP. We have demonstrated statistically significant improvement for two consecutive years for this PIP. This PIP project was completed and closed out in April 2020.

2. Medi-Cal PIP: Improving Well-Care Visits for Children in Their First 15 Months of Life (W15) for CalOptima Medi-Cal Members with Provider Office A

Goal
By June 30, 2021, increase the percentage of well-child visits among Medi-Cal members turning 15 months old for Provider Office A, from 41.51% to 51.61%.

Proposed Interventions
Provider and member incentive to increase well-child visits in the first 15 months of life.

1. Member incentives:
    - $50 for completed well-child visits 1-3
    - $50 for completing well- child visits 4-6
2. Providers are to receive the same amount verified through claims and encounters.

DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

3. **Medi-Cal PIP: Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County.**

    Goal
    By June 30, 2021, increase the rate of acute and or preventive care services among Medi-Cal members 18 years and older identified as experiencing homelessness in Orange County from 41.8% to 43.2%.

    Proposed Interventions
    Implementing HCAP to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.

    DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project. Awaiting guidance from DHCS to establish new PIP requirements at the end of 2020.

CCIPs: OC and OCC and NCQA Emerging Risk Standard – Medi-Cal

Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8%

The improvement project targeting the emerging risk populations aimed at improving A1C Control <8% for Members Recently Experiencing Poor Control >8%. This intervention targets Medi-Cal, OC and OCC. The Medi-Cal results will be reported to NCQA to satisfy the Emerging Risk standard. The OC and OCC results will be reported to CMS as part of a CCIP.

1. **OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021**

    Goal
    Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OC members identified and who participate back to an A1C <8% within one year.

    Target Population
    OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

- Exclusion criteria:
  - Ineligible CalOptima members
  - Members identified for long-term care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OC members with diabetes with A1C results trending upward from <8% to >8%. OC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results: The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessment	No Longer Eligible
2020	Q1	OC	0	0				
2020	Q2	OC	8	0	0	0	0	0

In Q1 2020, there were no OC members that were assigned to a health coach. (Only one member at the time and was recently outreached by a health coach on 12/31/2019.) For Q2 2020, there was eight in the starting denominator, but none were assigned due to accidentally assigning the Medi-Cal and OCC members first. Will prioritize OCC members first for Q3 2020.

2. OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2020

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an A1C <8% within one year.

Target Population
OCC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members were enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for LTC or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets OCC members with diabetes with A1C results trending upward from <8% to >8%. OCC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	OCC	4	4	2	0	0	0
2020	Q2	OCC	85	8	6	1	1	0

In Q1 2020, 4 members were assigned to a health coach and 2 were successfully outreached telephonically. In Q2 2020, 8 members were assigned to a health coach and 6 were successfully outreached telephonically.

3. Medi-Cal CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to Medi-Cal members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of Medi-Cal members identified and who participate back to an A1C <8% within one year.

Target Population
Medi-Cal members at risk for poor control >8% who were previously in good control <8% based on recent labs.

- These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
- Exclusion Criteria:
  - Ineligible CalOptima members
  - Members identified for long-term Care (LTC) or dementia
  - Members delegated to Kaiser

Interventions
This intervention targets Medi-Cal members with diabetes with A1C results trending upward from <8% to >8%. Medi-Cal members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned

approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results
The program was implemented in Quarter 4, 2019. Data collection for the intervention started 2020.

Emerging Risk Health Coach Telephonic Outreach (Medi-Cal)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached (#5 Yes)	Emerging Risk Members Unsuccessfully Outreached (#5 No)	Emerging Risk Members Incomplete Assessments	No Longer Eligible
2020	Q1	Medi-Cal	148	143	39	5	1	0
2020	Q2	Medi-Cal	731	35	22	1	12	0

In Q1 2020, 143 members were assigned to a health coach and 39 were successfully outreached telephonically. In Q2 2020, 35 members were assigned to a health coach and 22 were successfully outreached telephonically. We will continue to track and monitor this CCIP.

PDSA Initiatives

1. PDSA – Improving Flu Vaccination Rates for the Medi-Cal Population

In September 2020, DHCS required all MCPs to conduct a PDSA rapid cycle project on a single performance measure of the MCPs/PSPs choice that focuses on a preventive care, chronic disease management, or behavioral health MCAS measure impacted by COVID-19. MCPs/PSPs should provide evidence to support their choice of PDSA topic. DHCS will be flexible on the format and types of interventions for the PDSA cycles to accommodate for COVID-19 barriers. CalOptima has chosen to improve the Adult Immunization Status (AIS) measure, with a focus on influenza vaccinations. We are currently working the planning portion of this project. This PDSA will continue through the end of 2021.

2. Initial COVID-19 QIP Submission

In September 2020, DHCS required all MCP/PSP plans to submit a brief COVID-19 QIP to DHCS. The initial COVID-19 QIP (due to DHCS on October 2, 2020) submission included a description of the MCP's/PSP's interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19. The second COVID-19 QIP submission (due to DHCS on March 1, 2020) should include a six-month progress update on the interventions and/or strategies. CalOptima has submitted the initial response back to DHCS on October 2, 2020.

SECTION 3: QUALITY OF SERVICE

Member Experience

CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

CalOptima monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and HN. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "8, 9 or 10."

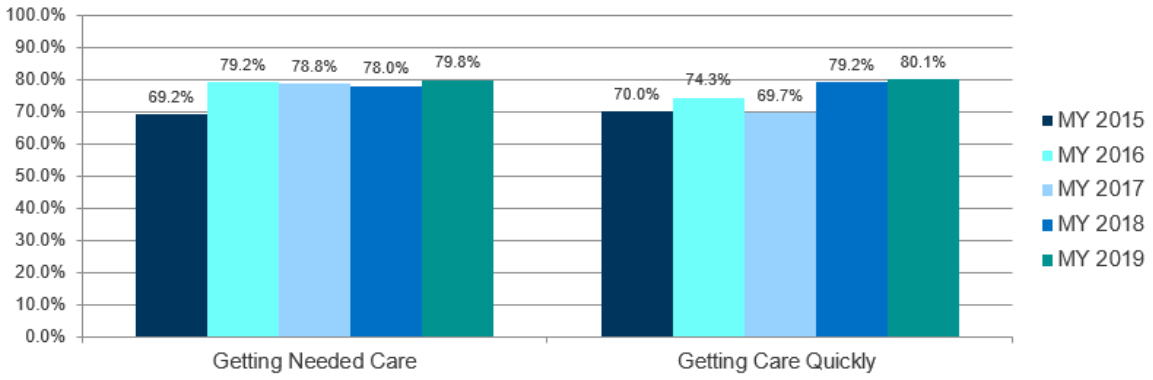
In early 2020, the world was struck by the COVID-19 pandemic. By mid-March, the state of California was under a state-wide lockdown (shelter-in-place) order. The CAHPS vendor's call center was closed and the vendor was unable to conduct the telephone follow-up calls. To address this issue, the survey protocol was modified from two mailings with a telephone follow-up to three mailings. While CalOptima's CAHPS survey still yielded approximately a 20% response rate, it's impossible to predict the effects of the pandemic on the survey results and survey results and any comparisons to trend data should be viewed with caution.

CAHPS Trend Analysis
CalOptima identified that the "Getting Needed Care and Getting Care Quickly" measures were consistently performing below goal. The following tables includes the plan level survey achievement scores for the adult and child surveys for two key measures (i.e. getting needed care and getting care quickly).

See next page for results.

Goal
To meet the 50th percentile when compared to National Medicaid Benchmarks.

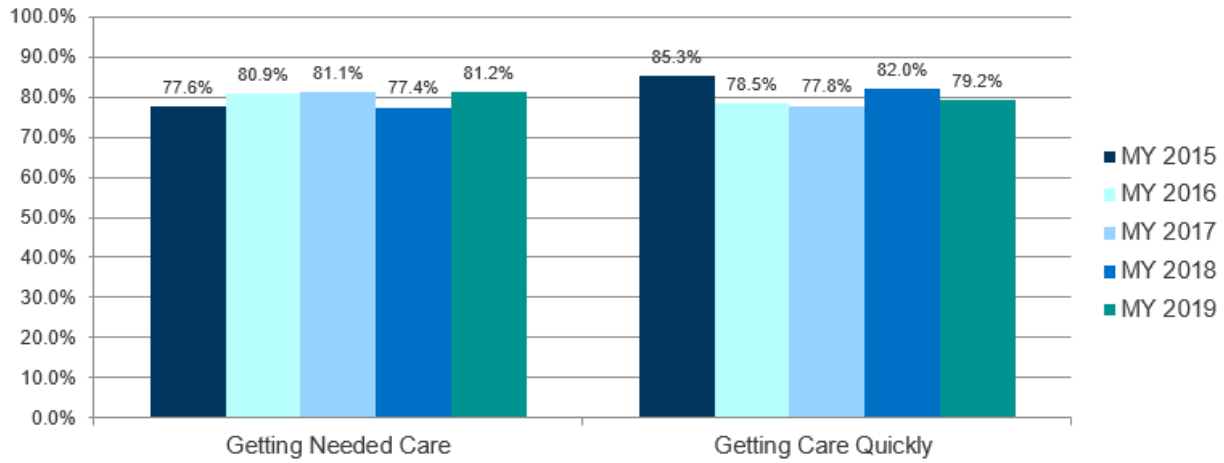
Medi-Cal Adult CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

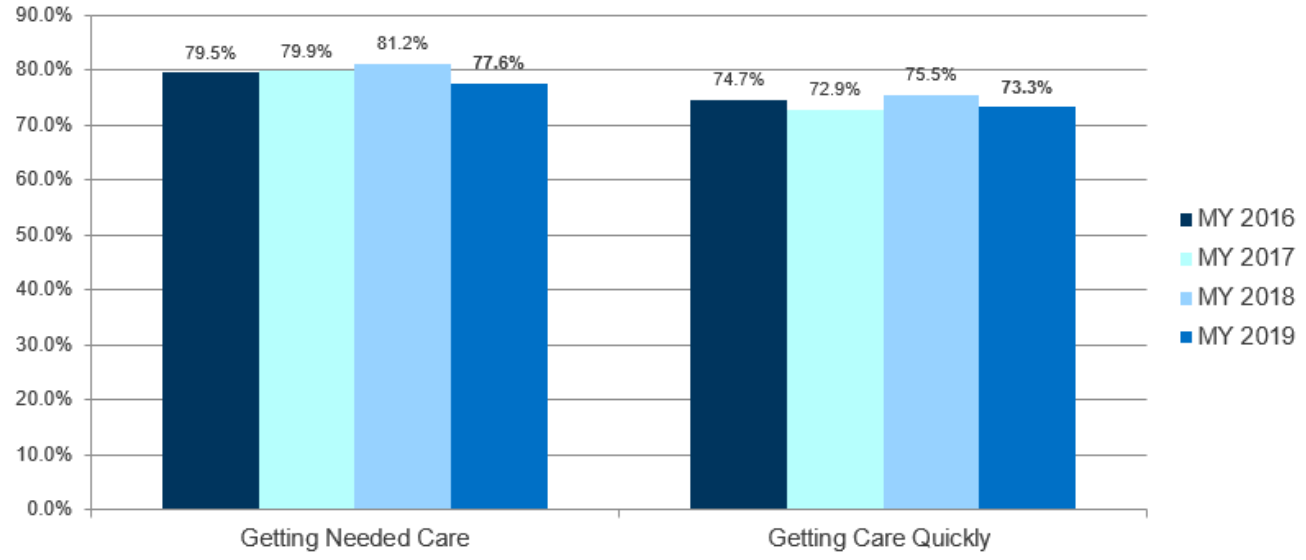
Medi-Cal Child CAHPS Survey Results



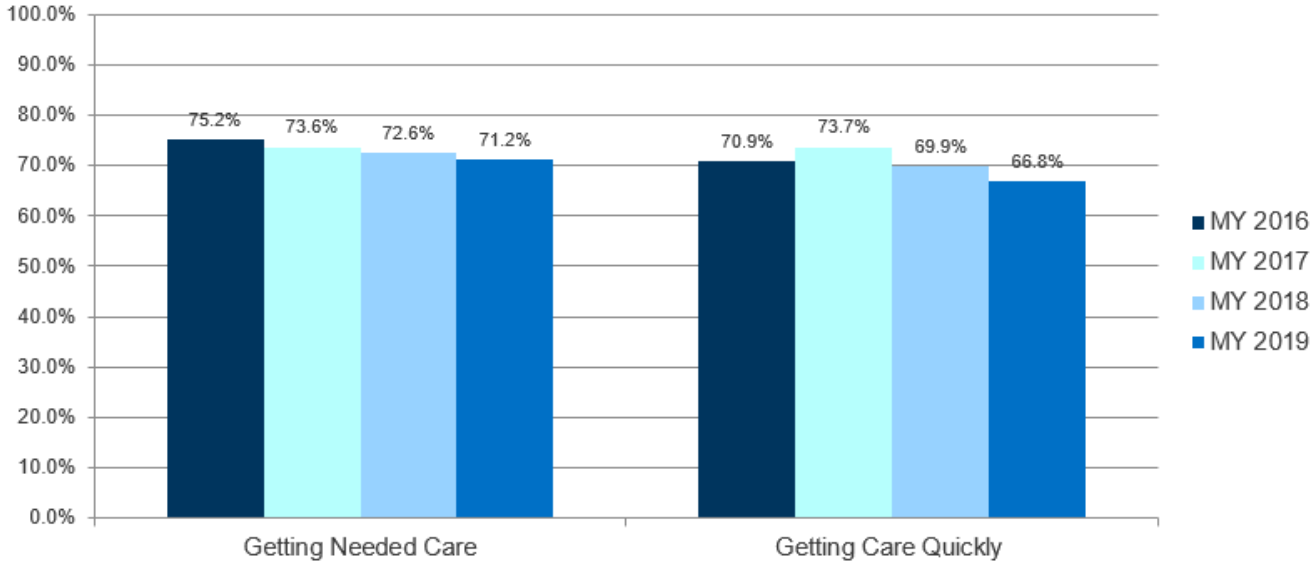
National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

OC CAHPS Survey Results



OCC CAHPS Survey Results



In 2020, CalOptima reviewed all the CAHPS rates in detail and compared them to the benchmarks and found the access CAHPS measures, getting needed care and getting care quickly, to be high priority for the organization.

Access to Care

Timely Access Study

CalOptima monitors appointment availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending and better overall member satisfaction with health care. CalOptima fields a mystery shopper timely access survey to collect appointment wait times and compares them to standards from DHCS and CMS. A compliance rate is calculated by appointment type for each provider type.

In early 2020, the world was struck by the COVID-19 pandemic. In light of the COVID-19 pandemic, CalOptima placed a temporary hold on conducting the Timely Access Survey to ease the burden and allow network providers to focus operations on COVID-19. This decision to hold place a hold on the survey is aligned with DHCS' discussion to hold their timely access survey of the plans. Since a 2020 survey has not yet been fielded, CalOptima utilized results from the 2019 Timely Access Survey to evaluate access.

As part of this survey, the survey vendor made 6,981 total contact attempts. Of that only, 71.1% of the contact led to a live contact and only 26.2% led to an appointment time that can be compared to the benchmark. The survey vendor was not able to reach a large portion of the provider survey population.

Goal:
To meet internal goal of 80% for each individual measure and practitioner types

Of the 26.2% of the survey population across all LOBs where the vendor was able to obtain an appointment for comparison against the standards, the data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. All of the standards by provider type, with the exception of physician exams for PCPs and follow-up appointments for non-physician behavioral health, did not meet the internal goal at 80%. Rates were particularly low for urgent appointments and appointments with specialists. Based on the review of timely access study results, appointment access is an area of concern. When evaluating timely access for each of CalOptima's delegated HNs, the HNs similarly did not meet the internal goal of 80% for most of the standards.

Network Adequacy — Time and Distance Analysis
CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the plan meets the time and distance standards established by CMS and DHCS. In 2020, DHCS issued an updated All-Plan Letter on Network Certification and provided more guidance on the meeting the standards and on how to run the reports. Plans are now required to meet both time and distance standards where each zip code must have members meeting 100% access and plans also need to account for anticipated membership using a methodology pulling from the 2010 census. For all LOBs, the plan has met the time and distance standards with the exception of ENT/Otolaryngology and Orthopedic Surgery and in one zip code in south OC for Medi-Cal. For these zip codes not meeting the standards, we have requested for approval for an alternative access standard with DHCS at the plan level and are awaiting DHCS' response. When evaluating network adequacy for each of CalOptima's delegated HNs, the HNs did not meet all the time and distance standards. HNs had challenges providing geographic coverage for specialists, particularly in south OC.

Comparison to Complaints/Appeals
When the CAHPS results were compared to the Access grievances, CalOptima found that access grievances make up about 10% of all grievances in 2020. Compared to the previous year, the percentage of access-related grievances have maintained the same as last year. The top three sub-categories of access grievances are appointment availability, specialty care, and referral related access grievances. Of the access-related grievances, appointment availability continues to be a pain point for members with approximately 26% of all access-related grievances.

In early 2020, as the world was struck by the COVID-19 pandemic, CalOptima received more Customer Service calls and grievances related to the pandemic. To better address these member concerns, a COVID-19 Member Experience workgroup was formed to monitor, track and trend COVID-19 related issues. The workgroup reviewed COVID-19 related calls from Customer Service, grievances, potential quality issues (PQIs) and provider calls and feedback. The top calls were related to COVID-19 testing, general inquiries about COVID-19 and inquiries about their provider and benefits, including pharmacy benefits. The top COVID-19 related grievances were related to delay in care and COVID-19 testing. For delay in care grievances, members were concerned about providers not seeing patients, appointment delay or cancelled appointments during the pandemic. COVID-19 testing related grievances were related to PCP/office not referring or denying member for testing or that the provider did not know where to refer the member for testing.

Member Experience Activities Completed in 2020
The Member Experience Subcommittee identified access, member engagement and virtual care strategies as the areas of focus for 2020.

Virtual Care Initiatives
A virtual strategies workgroup was formed to implement virtual initiatives to improve access to care. The workgroup also worked to identify resources and staffing as well and guide request for proposals and contracting efforts with vendors. On May 7, 2020, CalOptima obtained Board approval for overall Virtual Care Strategy and Roadmap.

1. Member Texting: CalOptima secured Board approval for three years of funding and contracted with mPulse on 7/28/20 to provide one-way and two-way interactive texting campaigns to members. Interface testing is in progress and the first two campaigns to be implemented will be COVID-19 and flu shots utilizing one-way messaging. Although we were technically ready to go in October, the campaign is on hold pending DHCS approval to use texting to communicate with members.
2. PACE Telehealth Solution: CalOptima secured Board approval for funding to implement a technology platform using VSee to support PACE staff (clinicians) virtual visits with participants at home or other remote locations that will replace the use of Facetime/Google Duo during COVID-19 and support long-term need to engage participants at home. Pilot was started in October and rolled out to all PACE clinical teams by early December.
3. eConsult: CalOptima intends to implement a system that allows PCPs and specialists to securely share health information and discuss patient care that may replace the requirement for authorizations. A RFP has been issued and vendor selection is targeted for January 2021.
4. Behavioral Health (BH) Virtual Visits: CalOptima contracted with Bright Heart to provide BH virtual visits to our members. Bright Heart providers have been credentialed and visits began in August 2020. BH providers have been utilizing referrals for BH services, and member liaisons have been utilizing referrals for medication management services.
5. 24/7 eVisits: CalOptima intends to provide 24/7 direct access to physician virtual visits via website link or nurse advice line referral. CalOptima obtained Board approval for funding to issue an RFP by December with a target to contract with a vendor by March 2021.

A Member Experience Subcommittee was held in the beginning of 2020, and the committee determined that, in addition to the virtual strategies listed above, the committee would aim to implement the following initiatives:

1. CalOptima contracted with SullivanLuallin Group, a customer service improvement health care consultant, to continue to conduct provider shadow coaching and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve overall patient experience. When the COVID-19 pandemic struck in March 2020, CalOptima suspended all SullivanLuallin in-person training efforts to provider offices to be in compliance with the state-wide mandate to shelter-in-place. Mid-year, CalOptima decided to sunset this program and focus efforts on improving access to our members during the COVID-19 pandemic. The contract with SullivanLuallin will expire near the end of the year.
2. Approximately 15 providers were sent a notification letter in 2020 to address PCP member panel overcapacity with panel closures and member reassignment. In light of COVID-19, CalOptima suspended the notification letters and panel closures mid-year to ease the burden and allow network providers to focus operations on COVID-19. In 2020, 10 PCPs had their panels re-opened because they had met capacity for three consecutive months.
3. The member portal release three and four were implemented in 2020.
    - New forms and user interfaces for new registrations, login, forgot password, logout pages, were successfully deployed in March 2020.
        - Multiple security enhancements were completed in March 2020.
        - A new COVID-19 related message was added to the member portal's landing page reminding members about self-service options such as ordering ID cards, changing PCPs, checking eligibility and submitting inquiries to Customer Service.
        - New member registrations continue increasing steadily at an average rate of 600 new members per week.
        - A Customer Service member portal support team responds to questions about the portal, helps members navigate site functions and provides basic troubleshooting of access issues.
    - Additional language support for Spanish and Vietnamese was deployed on 5/30/20.
    - New member representative forms and registration wizards were deployed on 5/30/20.
    - Interpreter services requests were successfully deployed on 5/30/2020.
4. CalOptima authorizations have been extended from 90 to 180 days to allow members more time to utilize the authorization and see their provider. This extension was particularly vital during COVID-19, when providers may be rescheduling patients' appointments due to the pandemic.
5. In 2020, through continued analysis of auto authorization rules in the Cerecons portal, an additional nine specialties were identified as having 98%+ approval rate and auto authorization rules developed and implemented for initial consults effective April 1, 2020.

During the COVID-19 pandemic, CalOptima implemented the following initiatives to immediately address the members' needs during the pandemic:

1. CalOptima updated the website to bring forth COVID-19 related information including information on how to get tested, pharmacy benefits, telehealth options and how to obtain additional resources.
2. Updated the CalOptima website search function for COVID-19 to make the content easier to find.
3. Customer Service staff conducts member outreach calls with an average of 1,200 members per month to wish happy birthday and reminder to get physicals. Effective March 2020 COVID-19 scripting replaced the birthday call script to education members on social distancing and availability of resources and services offered by CalOptima and 211. Calls also inform members

of medical benefits during the pandemic with additional care options such as telehealth visits and nurse advice line.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time and Distance Analysis and complaints data, the general theme that stands out is that appointment access and delay in care is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2021, CalOptima will continue focusing on the key initiatives that were implemented in 2020 and develop additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers

Based on the CAHPS and member complaints data, CalOptima has identified that getting needed care and getting care quickly are the most critical measures, and therefore are the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

Access and Availability

1. Lack of extended office hours for appointments can be a significant barrier.
2. PCPs have too many members in their panel.
3. There may be an adequate number of practitioners in CalOptima's panel but not all providers have open panels or are available to see CalOptima new patients.
   - CalOptima is a delegated model and members are only able to see a provider in their HN.
   - A particular PCP and specialist group will not see members that are not in their system.
4. Certain geographic areas in OC, particularly south OC, do not have an adequate number of specialists for a particular type of specialty (i.e. pediatric subspecialties, oncologists, rheumatologists, etc.).
5. Not enough specialists are willing to contract with CalOptima.
   - Low reimbursement rates in comparison to other types of health insurance.

Provider Data Quality

1. Members not always able to get through to their provider to make an appointment.
   - Member calls reached voicemail, a closed office, an answering service or no answer at all
2. Members are referred to and approvals are sent to specialists who cannot see the patient.
   - Specialists/subspecialties/area focus is not clear, or information is not captured.
3. Open/close panel is not up-to-date
   - No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
4. System issue: FACETS shows no longer accepting patients, but Guiding Care shows as participating without any restrictions.

Prior Authorization Process

1. Timelines of submission of PCP and specialist in an issue. Provider office staff wait to submit the authorization request.

2. Providers do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometimes required and may cause delay in obtaining services.
3. Since UCI provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process which may make members feel like it takes a long time.

Opportunities for Member Experience in 2021

The Member Experience Subcommittee identified access to care as the areas of focus for 2021. CalOptima has established the goal of improving member experience for getting needed care and getting care quickly from 25th to 50th percentile.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

1. Implement the virtual care initiatives in the Virtual Care Strategy and Roadmap, including implementation of an eConsult system to serve as a peer-to-peer communication messaging platform between PCPs and specialists which will improve patient access to specialty care and overall quality of care.
2. Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
3. Monitor Time and Distance Standards by HN. While DHCS is requiring all plans to certify their delegated networks on network adequacy access performance by July 1, 2022, CalOptima will begin monitoring adequacy of network at the HNs level and developing implementation plans, as needed, in 2020 to ensure that each HN meets time and distance standards.
4. Member portal release five development scheduled for deployment at end of Q3-2020. Enhancements targeted include redesign of Change of PCP forms, improved filtering of Medical Groups on Provider Search results, update position of Medical Group Affiliations fields, and general enhancements to the dashboard.
5. Need to accelerate member portal adoption in 2021 provider outreach and education via a notification letter to providers not meeting the timely access standards. An escalation process has been developed to track continue instances of non-compliance that may lead to further action (i.e. corrective action plan, freezing panels, sanctions, etc.).

RECOMMENDATIONS FOR 2021

Based on the 2020 QI Program Evaluation we recommend the following initiatives and projects to drive improvement in quality outcomes that impact our members.

1. Continue and expand member "health rewards" incentive programs by utilizing a contracted vendor experienced in increasing member engagement, specifically for preventive screenings. Vendor will offset use of intensive staff resources and facilitate expansion to other programs to narrow gaps in care. Work collaboratively with health networks to widen the promotion of member "health rewards" programs.
2. Intensify targeted member outreach, by utilizing multiple modes of communications per members preference, either through website, direct mailings, email, IVR calls, mobile texting, on-site member outreach and member engagement activities such as (e.g. mobile mammography clinic, back-to-school wellness, adolescent health immunization clinic, etc.).
3. Continue to utilize P4V Measure set to drive improvement on MCAS measures. Staff will consider the addition of new access measures to the P4V program for MY2021.
4. Institute new behavioral health (BH) P4V program in 2021 to help drive improvement in BH measures.
5. Prioritize data bridge efforts to improve data exchanges, both at the HN level and plan level in anticipation of many hybrid measures converting to administrative measures. Continue data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 include improving access to electronic medical record systems; and remedy the lab data gap not currently available through limited contract data exchanges.
6. Expand Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, e-visits, and telehealth for CalOptima's Program of All-Inclusive Care for the Elderly (PACE).
7. Continue to partner with UCI's Orange County Nursing Home Prevention Team to create on-line toolkits, videos, posters, and binder resources, as well as offer webinars and consultative sessions to help stop the spread of COVID-19 in nursing homes.
8. Continue to offer the Post-Acute Infection Prevention Quality Incentive (PIPQI) to nursing facilities who administer the Chlorhexidine (CHG) antiseptic soap in order to reduce the number of nosocomial infections as well as acute care hospitalizations related to infections for LTC members.

Based on the thorough 2020 QI Program Evaluation — in addition to continuing to advance CalOptima mission and improving quality outcome of our members — we recommend the implementing the 2021 Quality Improvement Goals in alignment with CalOptima's Strategic Priorities.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 1, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Approval of the CalOptima 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Contacts
Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Action
Approve the 2021 Quality Improvement Program and 2021 Quality Improvement Work Plan

Background
As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (QI Program) and Quality Improvement Work Plan (QI Work Plan) must be reviewed, evaluated, and approved annually by the Board of Directors.

The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detailed objectives, scope, timeline, monitoring, and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year and reported to the QI Committee quarterly.

CalOptima staff has updated the 2021 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks, and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

Discussion
The 2021 QI Program is based on the Board-approved 2020 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:
1. Updated signature page to reflect Interim Chief Medical Officer Emily Fonda, M.D., Quality Assurance Committee Chair Mary Giammona, M.D., and Board of Directors' Chair Andrew Do

2. Updated 2020 to 2021 dates throughout program, including up-to-date demographics on membership

Back to Agenda

3. Updated Program Initiatives section to initiatives for 2021:
    a. Improve Health Equity and Mitigate the Impact of the COVID-19 Pandemic
    b. Whole Person Care
    c. Health Homes Program
    d. Homeless Health Initiative
    e. Pharmacy Administration Changes
    f. Virtual Care Strategy

4. Updated the Roles of CalOptima Officers for the QI Program to reflect current organizational roles and responsibilities.

5. Updated 2021 QI Goals and Objectives:
    a. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during the COVID-19 pandemic.
    b. Improve member access to care by 10% from 2019 baseline.
    c. Achieve Accredited NCQA status post 2021 Health Plan Renewal Survey and maintain overall rating at 4.0.

6. Updated language in the Facility Site Review and Medical Record sections to reflect current regulatory descriptions.

7. Moved language related to the description of QI projects standards and documentation from Quality Analytics section to the Population Health Management section.

8. Updated the 2021 Delegation Grid to reflect delegated activities consistent with 2020 NCQA Standards, and regulatory requirements.

9. Incorporated recommendations from the 2020 QI Evaluation into the 2021 QI Workplan.

The recommended changes are designed to better review, analyze, implement, and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

Approval of the 2021 QI Program and QI Work Plan will does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff will include updated expenditures for the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget.

Back to Agenda

Concurrence
Board of Directors' Quality Assurance Committee
Gary Crockett, Chief Counsel

Attachments
1. Proposed 2021 Quality Improvement Program and Work Plan_(UpdatedRedline version)
2. Proposed 2021 Quality Improvement Program and Work Plan (Clean version)
3. PowerPoint Presentation: Updated Quality Improvement (QI) Program Evaluation Recommendations and Updated 2021 Quality Improvement Workplan

/s/ Richard Sanchez — *03/24/2021*
Authorized Signature — **Date**

Back to Agenda

~~Reviewed by MKC 12-03-20~~

~~2020~~2021

QUALITY IMPROVEMENT PROGRAM

~~2020~~ 2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

_____

~~David~~ Emily Fonda~~Ramirez~~, M.D. _____ **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

_____

~~Paul Yost~~Mary Giammona, M.D. **Date**

Board of Directors Chair:

_____ _____

_____

Back to Agenda Back to Item

~~Paul Yost~~~~Mary Giammona~~Andrew Do~~, M.D.~~

Date

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members ~~is~~ was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our 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.

Our Values — CalOptima CARES

Collaboration~~:~~

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability~~:~~

We were created by the community, for the community, and are accountable to the community. The following ~~Meetings~~ meetings are open to the public ~~are~~: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect~~:~~

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.

- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (~~OC~~ HCA).
- Substance use disorder services are administered by ~~OC~~ HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including ~~Orange County Health Care Agency (OC~~ HCA~~)~~ and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated

services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare ~~benefits~~. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure ~~each~~ members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: ~~from~~ COVID-19 Pandemic[SG1][OE2]

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, ~~as well as~~and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. -Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. -The COVID-19 pandemic shined a ~~blazing~~ bright light on the health disparities and inequity. -The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths~~,~~ but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima ~~has~~ identified opportunities to improve health equity as laid out in its~~the~~ QI ~~w~~Work ~~p~~Plan. -Additionally, the COVID-19 pandemic adversely impacted the mental health of ~~all~~[CM3]-many members, especially ~~for~~ children. -Hence, several trauma-informed interventions ~~will be~~are included in the 2021 QI ~~w~~Work ~~p~~Plan to address the toxic stress and Adverse Childhood Experiences (ACEs~~S~~) related to the COVID-19 pandemic.~~Intervention Team (ACE IT) was developed to provide members who screen positive or at moderate risk level for ACEs access to supportive services, with the goal to help members develop resiliency and minimize negative impact of ACEs on health outcomes.~~

~~Whole Person Care~~Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017~~–~~2019 Strategic Plan. In Orange County, the pilot is being led by the ~~OC~~ HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. ~~For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.~~ However, WPC ~~is~~was scheduled to terminate on December 31, 2020~~,~~; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition

was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implemented HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During the implementation, of HHP,

CalOptima's goal is to targeted the highest risk 3–5% percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing--related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.CalOptima has partnered with the OC HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers that they have been working with for their housing--related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. 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 support services; community connrrections[SG4][OE5]; and public social services. The county's WPC program 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, recuperative care services provide post-acute care for up to 90- days for homeless CalOptima members:. OC HCA and CalOptima split the cost of recuperative care on a 50/50 basis;. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to OC HCA in connection with the Whole--Person Care program, and the CalOptima Board of Director's has authorizationed tothe extendsion of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.-
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to OC HCA to provides additional respite care beyond the 90 days of recuperative care under the Whole--Person Care program.- These grant funds have been exhausted.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency'sHCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in -person.
-
- Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventative care services and care coordination helps connect the member back to the primary care delivery system.- Community health centers work with nearby shelters and hot spots that meet the program requirements and will receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we will beare able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima will have be able to provides preventive screenings, and chronic care, care coordination, and follow- up.

- ~~The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.~~

- Hospital Discharge Process for Members Experiencing Homelessness—~~-~~Support is provided to assist hospitals with the increased cost associated with discharge planning under ~~new~~ state requirements.

Pharmacy Administration Changes

It is expected that, e~~E~~ffective April 1, 2021, the Department of Health Care Service (DHCS) ~~is~~will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing,~~/~~/ prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima--retained responsibilities will include physician-administered drug claims processing~~/~~, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board.– This change is for the Medi-Cal program only, and does not affect the ~~OC/OCC~~OneCare/OneCare Connect, and PACE [SG6][OE7]~~programs~~ lines of business.

Virtual Care Strategy

In 2020~~1~~, ~~the~~ federal and state rules and regulations provided~~ing~~ limited waivers for telehealth due to the COVID-19 pandemic~~,~~ that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter--at--home measures. -Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various ~~V~~virtual ~~C~~care s~~S~~trategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management~~;~~.

2. Leverage existing delivery model where possible~~;~~.

3. Be proactive in seeking out opportunities to innovate.~~; and~~

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work ~~p~~Plan. With these ~~V~~virtual ~~C~~care ~~S~~strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. ~~1)~~ Improved member access and convenience.

2. ~~; 2)~~ Reduced avoidable in-person visits to specialists.~~; and 3)~~
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: ~~I~~improved member experience~~;~~, ~~A~~augmented network capacity and adequacy~~;~~, and ~~I~~improved clinical quality outcomes.

~~*Behavioral Health for OC/OCC*~~

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1,2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.~~

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima ~~H~~health n~~N~~etwork (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. ~~Members enrolled in CalOptima Direct Administrative are not HN eligible.~~

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly ~~internally~~ by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for ~~growth~~access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)

- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following ~~13 Hhealth Nnetworks~~HNs[SG8][OE9]:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	~~SRG~~	~~SRG~~
Family Choice Medical Group		SRG	SRG
~~Heritage~~ HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch ~~Family~~ HealthCare	~~HMO~~	SRG	~~HMO~~
Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan~~Medical Group~~	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management ~~(UM)~~
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer ~~S~~services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

[OE10]

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~ Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA and meet DHCS/CMS quality ~~requirements~~ and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- ~~Sets~~ Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.~~.~~
- ~~Supports~~ Supporting the provision of a consistent level of high quality ~~of~~ care and service for members throughout the contracted provider networks, as well as ~~monitors~~ monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.~~.~~
- ~~Provides~~ Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  ~~Ensures~~ Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority~~—OC~~ HCA—which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.~~, as reported by the HNs~~[SG11]~~.~~
- ~~Promotes~~ Promoting patient safety and ~~minimizes~~ minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and ~~works~~ working with appropriate committees, departments, staff, practitioners, provider medical groups~~,~~ and other related O~~o~~rganizational P~~p~~roviders (~~OPS~~OPs) to assure that steps are taken to resolve and prevent recurrences.
- ~~Educates~~ Educating the workforce and ~~promotes~~ promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes ~~apply to populations served~~are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations~~, to~~:

- Support~~ing~~ the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently~~.~~
- ~~The c~~Continuously improve~~ing~~ment ~~of~~ clinical care and service~~s~~ quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population~~.~~

- ~~The t~~Timely identifying ~~ication of~~ important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high- risks, and disease profiles for both acute and chronic illnesses, and preventive care~~.~~
- ~~The~~ Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities~~.~~
- ~~The~~ Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population~~.~~
- ~~The~~ Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service~~.~~
- ~~The~~ Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances~~.~~
- ~~The~~ Ensuring the reliability of risk prevention and risk management processes~~.~~
- ~~The~~ Ensuring compliance with regulatory agencies and accreditation standards~~.~~
- ~~The accountability cadence of~~Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans~~.~~
- ~~The~~ Promoting the effectiveness and efficiency of internal operations~~.~~
- ~~The~~ Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs~~.~~
- ~~The~~ Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values~~.~~
- ~~The~~ Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES~~,~~ AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's s~~S~~tate and f~~F~~ederal ~~C~~contracts — and to CalOptima's Chief Executive Officer (CEO), as ~~discussed~~ described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify ~~the~~ member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with ~~F~~federal and ~~S~~state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and ~~review and~~ make recommendations to the Board regarding ~~accepting~~ the overall QI Program. QAC ~~and annual evaluation, and~~ routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives~~,~~ and ~~improvements~~quality performance results achieved. The QAC also makes recommendations to the Board for ~~for~~ annual approval with modifications and appropriate resources allocations of the QI Program ~~and actions~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim~~, moving upstream from the~~(which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation~~,~~ and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preven~~ta~~tative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons ~~—~~ ~~M~~medical ~~S~~safety ~~N~~net
- ~~OC HCA~~
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs ~~—~~ ~~B~~behavioral/~~M~~mental ~~H~~health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by ~~OC~~ HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and ~~C~~c~~C~~ommunity-~~B~~b~~B~~ased ~~S~~s~~S~~ervices [SG12](HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - ~~OC HCA, Behavioral Health~~
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent ~~a~~ the broad provider community that serves CalOptima members. The PAC ~~is comprised of~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of ~~OC~~ HCA, which maintains a standing seat. PAC meets at least quarterly and ~~are~~ is open to the public. The 15 seats include:

- ~~HN~~ Health networks
- Hospitals
- Physicians (three ~~3~~ seats)
- Nurse
- Allied health services (~~2~~two seats)
- Community health centers
- ~~OC~~ HCA (~~1~~one standing seat)
- LTSS (LTC facilities and CBAS) (~~2~~ ~~1~~one seat~~s~~)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

~~In 2018, CalOptima's Board of Directors established the~~ Whole-Child Model Family Advisory Committee (WCM FAC), ~~a~~~~is~~has been required by the state as part of California Children's Services (CCS) ~~when~~since it bec~~o~~am~~e~~~~ing~~ a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: ~~7 9~~seven to nine seats

    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are ~~a~~ current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
    - ~~o~~
- Interests of children representatives: ~~2 to~~ 4two to four seats
    - Community-based organizations; or
    - Consumer advocates

Members of the c~~C~~ommittee shall serve staggered two-year terms. ~~Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term.~~ WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the s~~S~~tate and f~~F~~ederal ~~Contracts~~contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) —oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met.– The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who, and serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the: Directors of, Quality Analytics,; Director,[CM13] Quality Improvement;, Director, Population Health Management;, Director, Behavioral Health Services (Clinical Operations); and Director, Behavioral Health Integration.

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, LTSS and MSSP Ssservices, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED of PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED of PI are the directors of both Process Excellence and : Director, Process Excellence; and Director, Strategic Development.

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED of C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to sState and Ffederal requirements.

Executive Director, Network Operations (ED of NO) leads and directs the integrated operations of the HNs, and must coordinate organizational efforts internally, as well as and externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, ~~Government~~ Public Affairs (Chief of Staff) ~~(New)~~ is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations~~,~~ and strategic development programs.~~ –~~ The ~~eChief of Sstaff~~ED ~~of~~ PA ~~will~~ assists the CEO in carrying out organizational goals~~,~~ and ~~will~~ planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

~~Add JD~~

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, t~~T~~he QIC oversees ~~in collaboration with the Compliance Committee~~ the performance of delegated functions ~~by monitoring~~by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes ~~a~~ participating practitioners ~~that~~who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed~~,~~ and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include ~~the following~~:

- ~~Recommends~~ Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- ~~Oversees~~ Overseeing the analysis and evaluation of QI activities.
- ~~Makes~~ Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.

- ~~Identifies~~ Identifying and ~~prioritizes~~ prioritizing needed actions and interventions to improve quality.
- ~~Makes~~ Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with ~~ABA~~applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with ~~4~~ four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data ~~and~~ collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter~~,~~ and includes, but may not be limited to~~, the following~~:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration

- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year~~,~~ and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §-14087.58(b), Health and Safety Code §-1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the c~~C~~ommittee ~~C~~chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of W~~w~~ork ~~p~~Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process,~~;~~ and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues

and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate~~,~~ and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its ~~program~~ lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-~~011~~023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 202~~0~~1, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least ~~bi-monthly~~quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 202~~0~~1 and MY 202~~1~~2 CAHPS survey results.

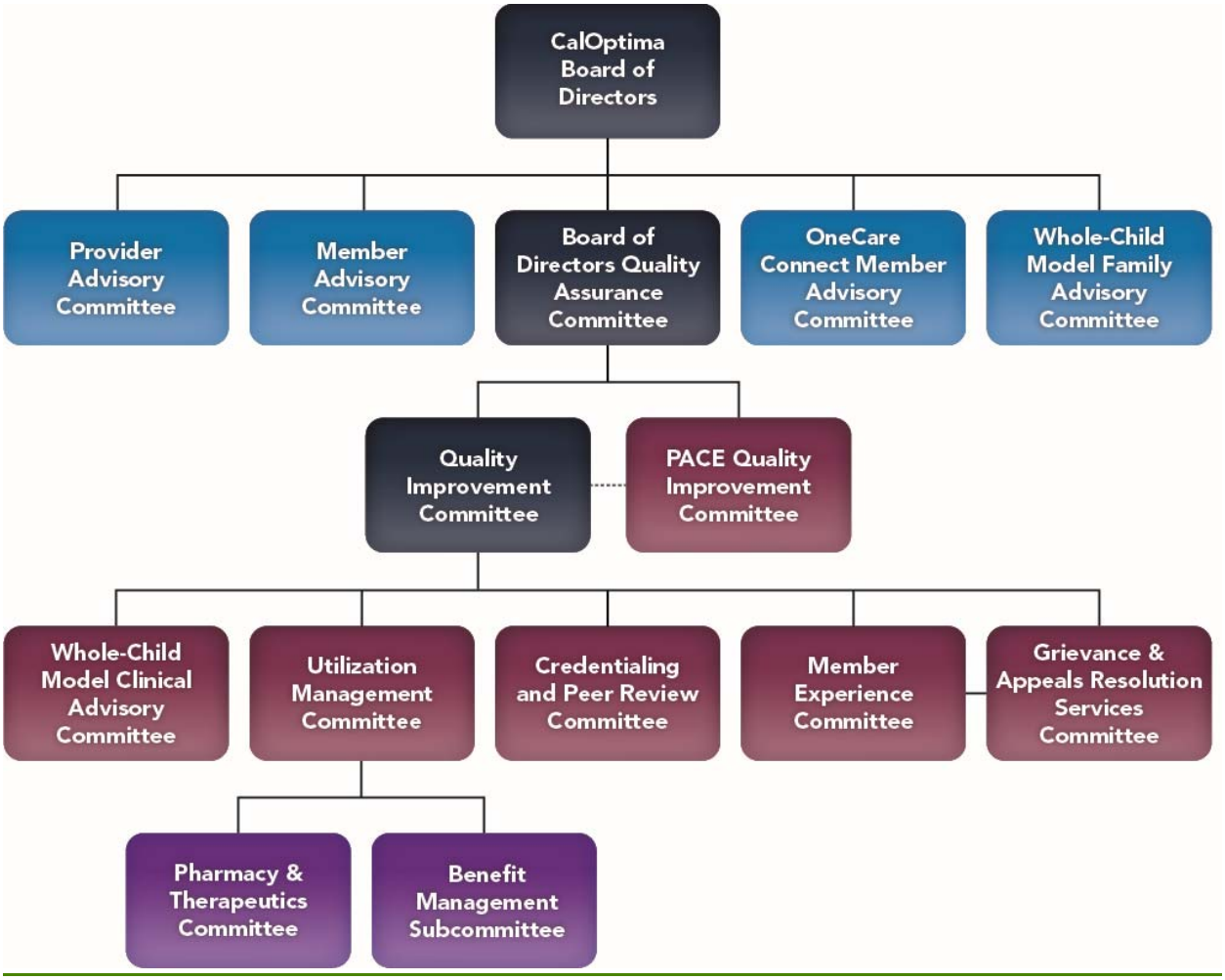
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

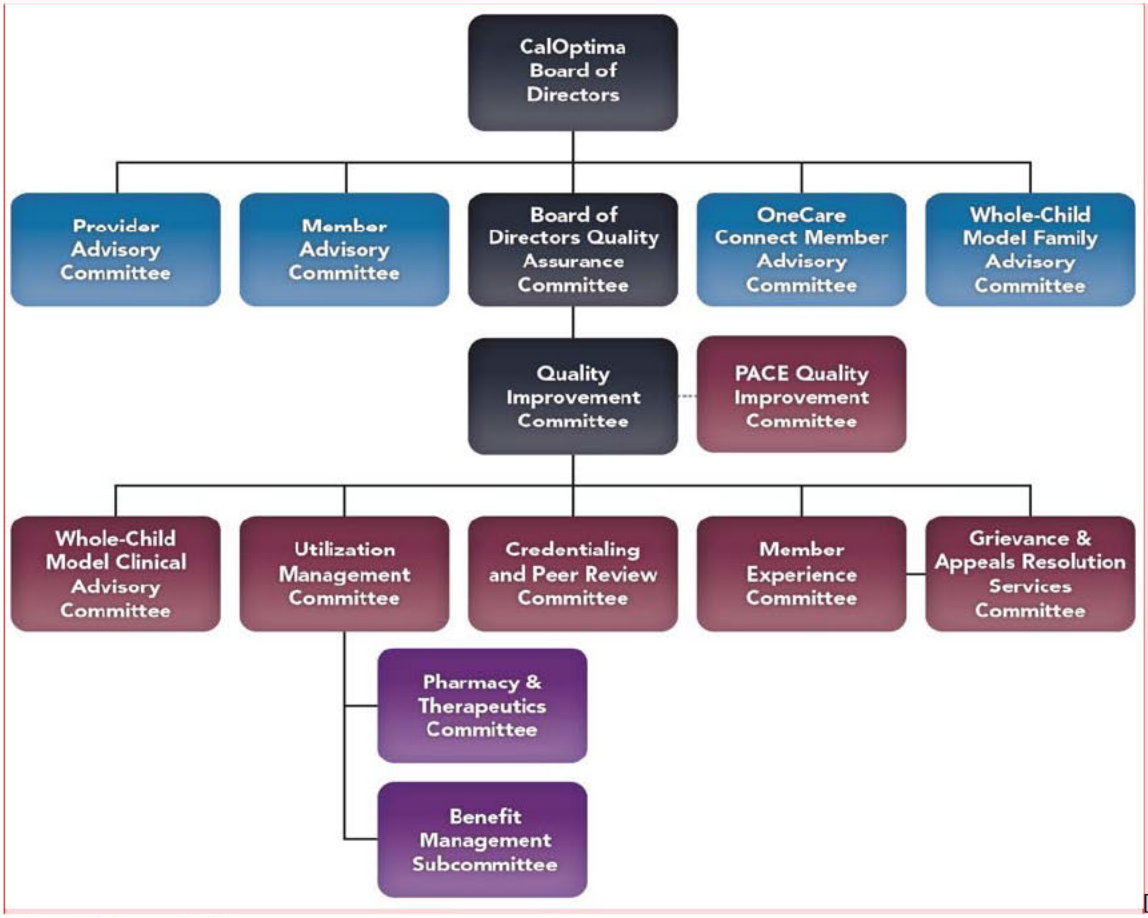
Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

~~2020~~ Committee Organization Structure — Diagram



Back to Agenda Back to Item



[GG14]

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

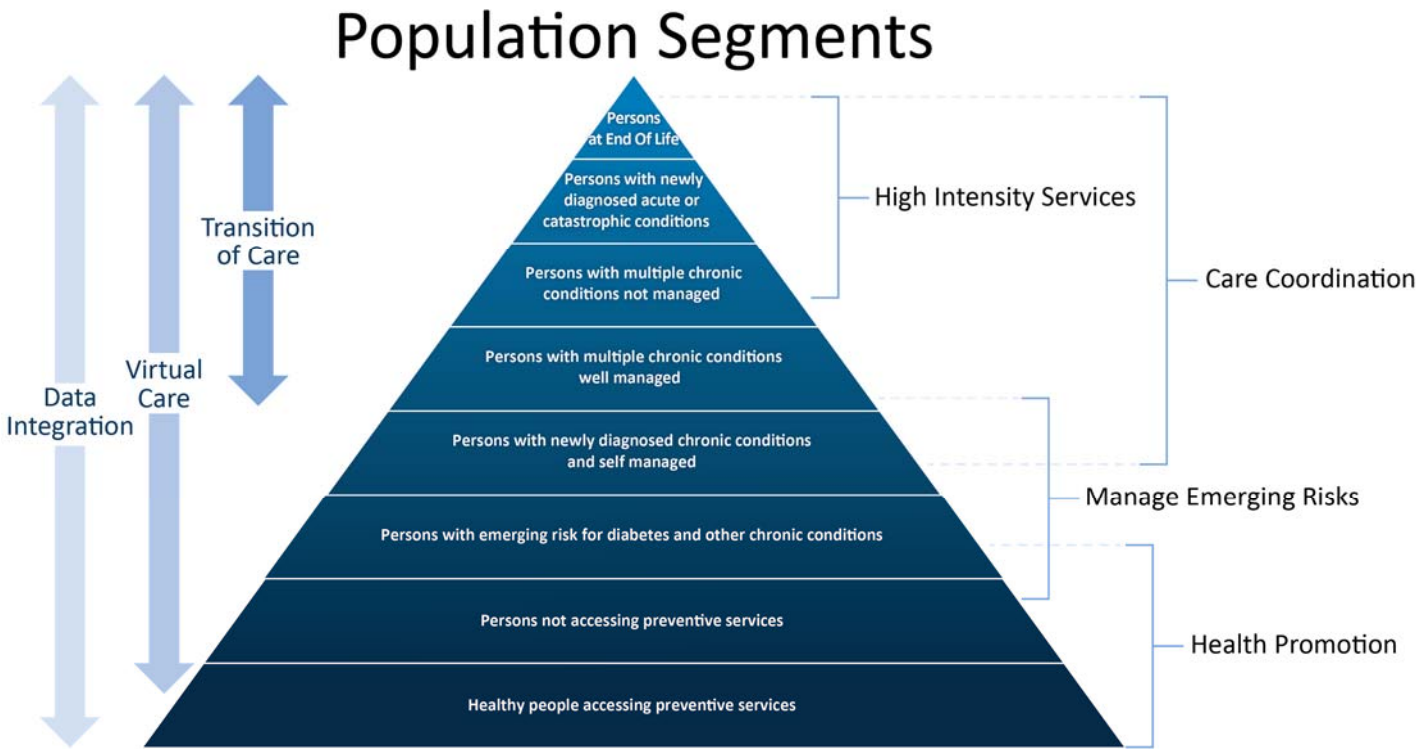
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure ~~supports~~ provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by~~,~~ stratifying the~~our~~ population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021~~0~~ QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



Back to Agenda Back to Item

CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

20210 QI Goals and Objectives[SG15][OE16]

CalOptima's QI Goals and objectives are aligned with CalOptima's 20210–20221 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

1.3. Achieve Accredited NCQA status post 2021 Renewal Survey, and mMaitainMaintain Increase NCQA overall rating from at 4.0 to 4.5
Improve

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA---Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

1. Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly
1. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

Detailed strategies for achieving 2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima ~~the~~ strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the s~~S~~tate or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities

- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care ~~to aid~~aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021~~0~~ QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.
- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement~~,~~ and ~~is occurring~~occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority~~, which~~ that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance~~,~~ (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, ~~M~~management, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross~~-~~-functional~~,~~ and require dedicated resources to assist in data collection, analysis~~,~~ and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality M~~m~~easures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers~~,~~ or predictors of the desired outcome measures or lag quality measure, such as HEDIS and ~~STARS~~ Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN~~s~~, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. ~~See explanation of Clinical Data Warehouse below.[SG17]~~

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with ~~5–10~~5–10% ~~percent~~ over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411~~,~~ and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% ~~percent~~ of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depend~~ent~~ing on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI ~~w~~Work ~~p~~Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors,~~–~~ through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad ~~-~~hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both web~~-~~site and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on ~~the our~~CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, ~~of~~ Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED ~~of~~, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - QI Nurse Specialists
  - Program Policy Analyst
  - Credentialing Coordinators
  - Program Specialists (including Intermediate and Senior)
  - Program Assistants
  - Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics Network Adequacy Manager
  - Quality Analytics Data Analytics Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management

Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dietietians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Integration
pProvides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration Ddepartment efforts in integrated care, quality initiatives, and community partnerships. The Ddirector ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
pProvides clinical operational oversight and leadership to the implementation, expansion, and/or improvement of processes and services s of the Behavioral Health Integration dDepartment clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and ~~utilization management~~UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
A assists in the development and implementation of the UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves

on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
~~l~~Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures,~~;~~ ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of ~~P~~pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics ~~c~~Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
R~~is r~~esponsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
~~is r~~Responsible for LTSS programs, which include CBAS, LTC~~,~~ and MSSP. The position supports a ~~"Member Centric"~~member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures~~,~~ and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
~~p~~Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and ~~roadmap~~road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the ~~roadmap~~road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the ~~e~~Enterprise ~~a~~Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-~~-~~specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)

- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training
- ~~QI Lean training curriculum (added to CalOptima University in 2019)~~

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC~~,~~ and QAC~~,~~ and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors' review and approval.

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight

- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

** CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.
  - Measure the member experience of accessing and getting needed care.
  - Empower staff to be more effective.
  - Coordinate and communicate organizational information, both division and department-specific, as well as agency-wide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agency-wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to

CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following:, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to:, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of organizational providers (OPs) such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with sState and Ffederal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Ffederal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care ~~practitioner~~ provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% ~~percent~~ on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR, and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.
~~Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full-scope site review performed by another health plan in the past three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.~~

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room

- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's~~'~~ medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.~~–~~ All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care~~,~~ in such a way that it facilitates communication, coordination and~~,~~ continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by ~~S~~state and ~~F~~federal laws and regulations, and the requirements of CalOptima's contracts with CMS~~,~~ and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable ~~F~~federal and ~~S~~state law.

~~**CalOptima requires that its contracted delegated HNs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.**~~

~~The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS.~~

~~The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.~~

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the ~~appropriate~~ relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance

Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.
- ~~Identification and reporting of medical disciplinary cause or reason issues to the appropriate state board.~~[SG18]
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- ~~Prescribed continuing education or office training~~
- ~~De-delegation~~
- ~~De-credentialing~~
- ~~Contract termination~~[SG19][OE20]

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.

- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider--specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members. and[CV21] practitioners.
- Provide agency-wide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case mManagement reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data, and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARStars and HOS measures. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping mMembers Hhealthy
2. Managing Mmembers with eEmerging rRisks
3. Patient Ssafety or Ooutcomes Aacross Ssettings
4. Managing Mmultiple Cchronic Cconditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, andwhich was adopted again in 2020. The 2019 PHM Strategy will continue into 2021,0 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&Lcultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct Qquality Iinitiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. QQuality Iinitiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 20210 are tracked in the QI Work Pplan and reported to the QIC.

In 20210, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions.

Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member--focused trauma informed care to be consistent with NCQA ~~2020~~ Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma--Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The ~~population health management~~PHM team also focuses on improvement projects such as QIP's, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

~~Interventions~~

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member--specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. ~~A.~~ Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. ~~B.~~ Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

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Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

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- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agency-wide ~~population health~~ PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, ~~and~~ Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, ~~that~~which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP

        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - ~~Meets~~ Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and ~~at~~ at high-risk individuals
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy,

psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated~~,~~ to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including ~~utilization management~~UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

~~CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1~~In~~,~~ 202~~1~~0, OC/OCC behavioral health ~~will~~ continues to be ~~be~~ fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021~~0~~ UM Program Description. ~~and related Work Plan.~~

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and ~~roadmap~~road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results~~;~~, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings, including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, critical incident identification, appropriate investigation, and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 Infection Prevention and Protective Equipment
  - MRSA prevention program (Shield)
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact~~;~~, 24-hour access to telephonic interpreter services~~;~~, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, ~~PDF~~ or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services

- QI program for all lines of business~~,~~ (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and ~~health care delivery~~ organizational providers (OPs)~~rganizations OP~~[SG22][OE23]
- Credentialing and re-credentialing of OPs~~of OPs~~[SG24]
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021~~0~~ Delegation Grid.

See Appendix B — 2021~~0~~ Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021~~0~~ QI Work Plan

APPENDIX B — 2021~~0~~ DELEGATION GRID

APPENDIX C — ~~QI~~ ORGANIZATIONAL CHART

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH)
B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure
D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program
E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Esther Okajima				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Esther Okajima				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, Collaboration with OC Coalition of Clinics to receive their aggregated EMR data, efforts to immunization registry (CA R) and lab data gaps (Blood Lead Testing results for example) Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COV D-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COV D-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal** **CCS -** MC 61 31% **COL** - OCC 73% OC 62% **BCS** - MC 58.82% OCC - 76% OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted member engagement and outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Targeted member engagement and outreach campaigns to promote colorectal cancer screenings in coordination with health network partners 4) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted member engagement outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Coordinate mobile mammography clinics in zip codes with low incidence of screening. 4) Track the number of mammograms scheduled through targeted outreach. 5) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COV D vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC NA;OCC:18 20%	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal** MC - Init Phase - 42.92% MC - Cont Phase - 54.73%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal MC NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal** MC 38.18% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal (A1C Poor Control)** MC 37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Targeted member engagement and outreach campaigns to promote Diabetes A1C testing in coordination with health network partners 3) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal (Diabetic Eye Exams)** MC: 58.64% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Targeted member engagement and outreach campaigns to promote Diabetes Eye Exam in coordination with health network partners 5) Member Health Rewards RFP and Vendor Contract 6) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 7) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal** Prenatal 89 05% Postpartum 76.40%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Implement Collaborative Member Engagement Event with OC Diaper Bank (3-4 times yearly) 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal** MC 65 83%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents; and track the number of participants for targeted adolescent "Back-to-School" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials 4)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 5) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	HEDIS MY2020 Goal: MC - NA OC 8%; OCC 0 85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Post-Acute Infection Prevention Quality Incentive (P PQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer lodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COV D Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COV D/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COV D-19 as soon as possible 2) Provide expertise on infection prevention for COV D-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COV D 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www ucihealth org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COV D-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

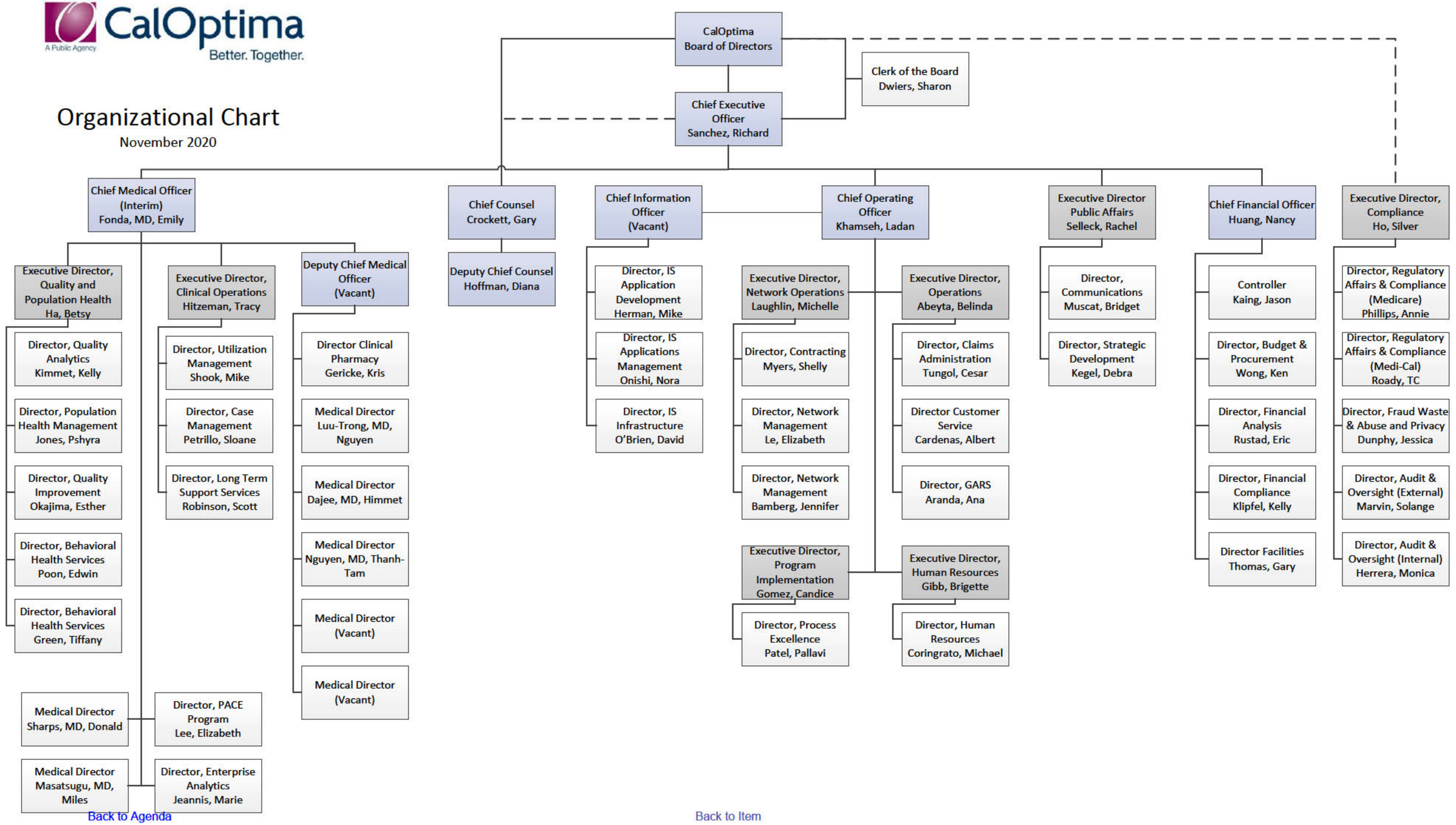
Back to Agenda Back to Item

APPENDIX C — ORGANIZATIONAL CHART

CalOptima
A Public Agency
Better. Together.

Organizational Chart

November 2020



Back to Agenda

Back to Item

CalOptima
A Public Agency
Better. Together.

2021

QUALITY IMPROVEMENT PROGRAM

2021 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Emily Fonda, M.D. **Date**
Interim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Mary Giammona, M.D. **Date**

Board of Directors Chair:

Andrew Do **Date**

Back to Agenda Back to Item

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members was in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our 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.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. The following meetings are open to the public: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through California's Denti-Cal program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and an out of the country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits, and transportation. OCC also includes personalized services through the PCCs to ensure members receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating, and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services—other than emergency care—from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

Program Initiatives

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE, and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, and the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in October 2020 revealed that Latinx account for 61.1% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 8% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as laid out in its QI Work Plan. Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. WPC was scheduled to terminate on December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity, rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program, and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD) and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing-related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers for their housing-related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. 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 support services; community connections; and public social services. The county's WPC program 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, recuperative care services provide post-acute care for up to 90 days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with the Whole-Person Care program, and the CalOptima Board of Directors has authorized the extension of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.

- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole-Person Care program. These grant funds have been exhausted.

- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in person.

  Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima provides preventive screenings, chronic care, care coordination, and follow up.

- Hospital Discharge Process for Members Experiencing Homelessness—Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.

Pharmacy Administration Changes

It is expected that, effective April 1, 2021, the Department of Health Care Service (DHCS) will be carving out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to the state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing, prior authorizations, formulary administration, and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will

include physician-administered drug claims processing, prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only, and does not affect the OneCare/OneCare Connect, and PACE lines of business.

Virtual Care Strategy

In 2020, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 pandemic that enabled CalOptima to accelerate its virtual care strategy under COVID-19 shelter-at-home measures. Members were able to receive appropriate health care services though telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:

1. Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management.

2. Leverage existing delivery model where possible.

3. Be proactive in seeking out opportunities to innovate.

4. Provide technology-agnostic solutions.

Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:

1. Improved member access and convenience.
2. Reduced avoidable in-person visits to specialists.
3. Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as: improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct (CalOptima Direct-Administrative and/or CalOptima Community Network (CCN)) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, who are not HN eligible, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following HNs:

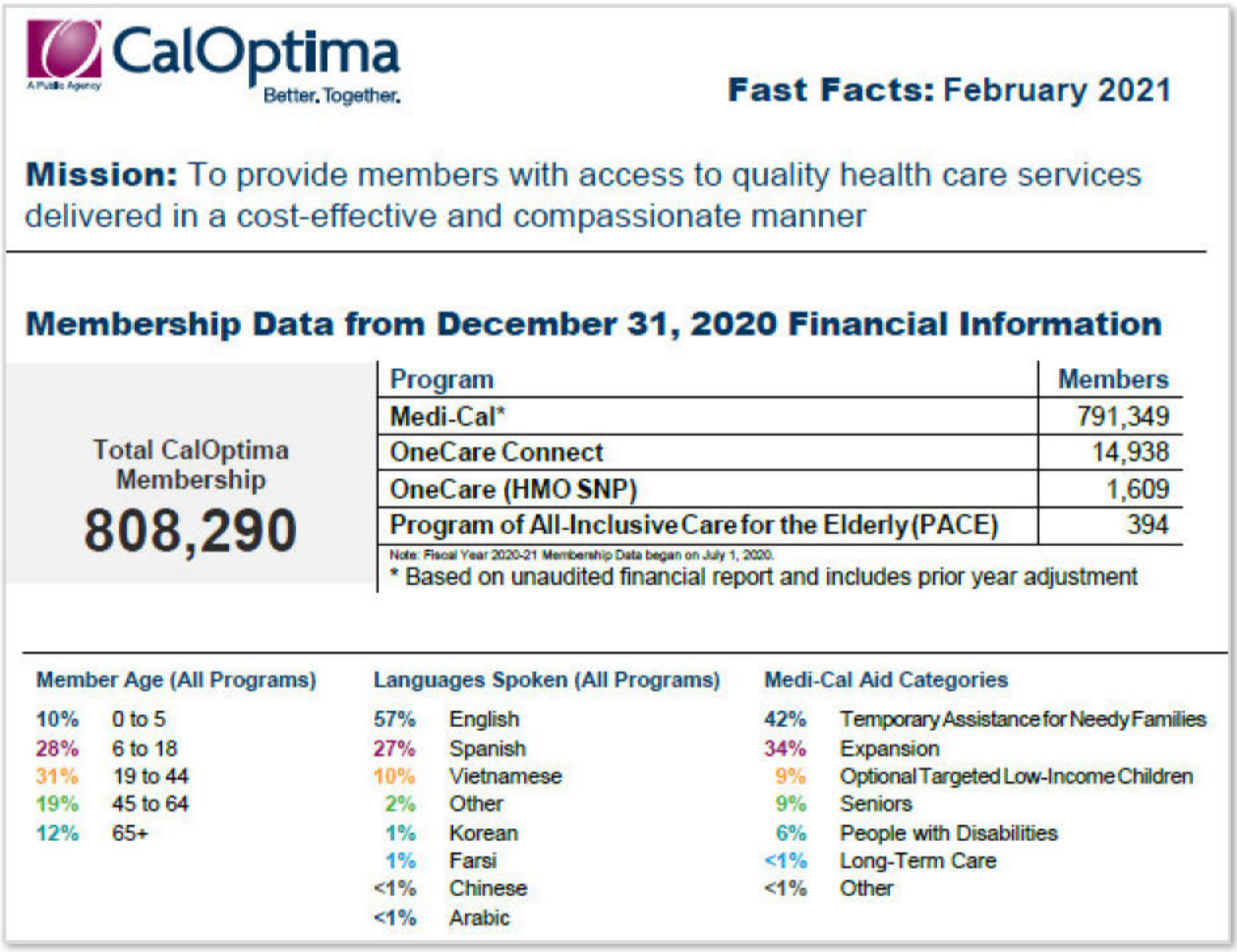
Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC		
Family Choice Medical Group		SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch HealthCare		SRG	

Monarch Health Plan, Inc.	HMO		HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer service activities

MEMBERSHIP DEMOGRAPHICS



CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the CMS Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program—and in collaboration with its providers and community partners—CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.

- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes.

- Supporting the provision of a consistent level of high quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

  Ensuring certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority—HCA—which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.
- Promoting patient safety and minimizing risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related Organizational Providers (OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD-A network providers serving CalOptima's various populations:

- Supporting the agency's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently

- Continuously improving clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population

- Timely identifying important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high risks, and disease profiles for both acute and chronic illnesses, and preventive care

- Ensuring continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities

- Ensuring accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population

- Monitoring the qualifications and practice patterns of all individual providers in the network to deliver quality care and service

- Promoting the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances

- Ensuring the reliability of risk prevention and risk management processes

- Ensuring compliance with regulatory agencies and accreditation standards

- Ensuring the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans

- Promoting the effectiveness and efficiency of internal operations

- Ensuring the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs

- Ensuring the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values

- Ensuring compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation and evaluation of the

overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons — medical safety net
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs — behavioral/mental health
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - OC SSA

- OC Community Resources Agency, Office on Aging
- OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent the broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC), has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: seven to nine seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives: two to four seats

- Community-based organizations; or
- Consumer advocates

Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care practitioner in the QI program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED,

Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the EDQ&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Case Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI are the directors of both Process Excellence and Strategic Development.

Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to state and federal requirements.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and must coordinate organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Public Affairs (Chief of Staff) is responsible for the oversight and measurement of CalOptima's communications, legislative, community relations and strategic development programs. The ED PA assists the CEO in carrying out organizational goals and planning, developing and implementing strategies to effectively communicate and implement the CalOptima mission with internal and external contacts, including employees, the public, members, providers, government officials, and the media.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- Overseeing the analysis and evaluation of QI activities.
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation, and review of QI program activities.
- Identifying and prioritizing needed actions and interventions to improve quality.
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners, and delegated health networks are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization, and recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code §14087.58(b), Health and Safety Code §1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates, and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of

application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-023. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations, and referrals for the "pain points" in health care that impact our members. In 2021, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2021 and MY 2022 CAHPS survey results.

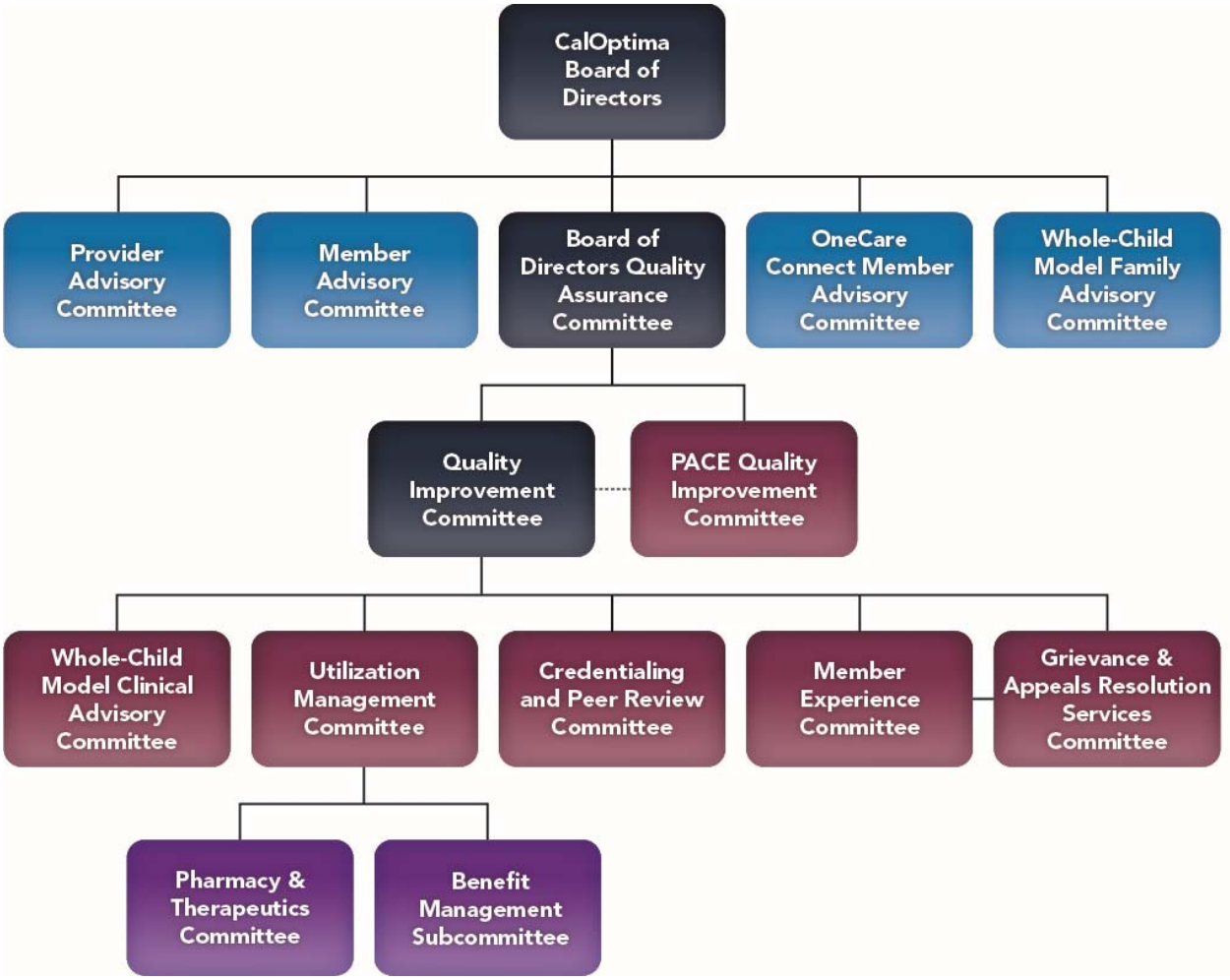
Grievance and Appeals Resolution Services Committee (GARS)

The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)

The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

Committee Organization Structure — Diagram



Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees—including contracted professionals who have access to confidential or member information—sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

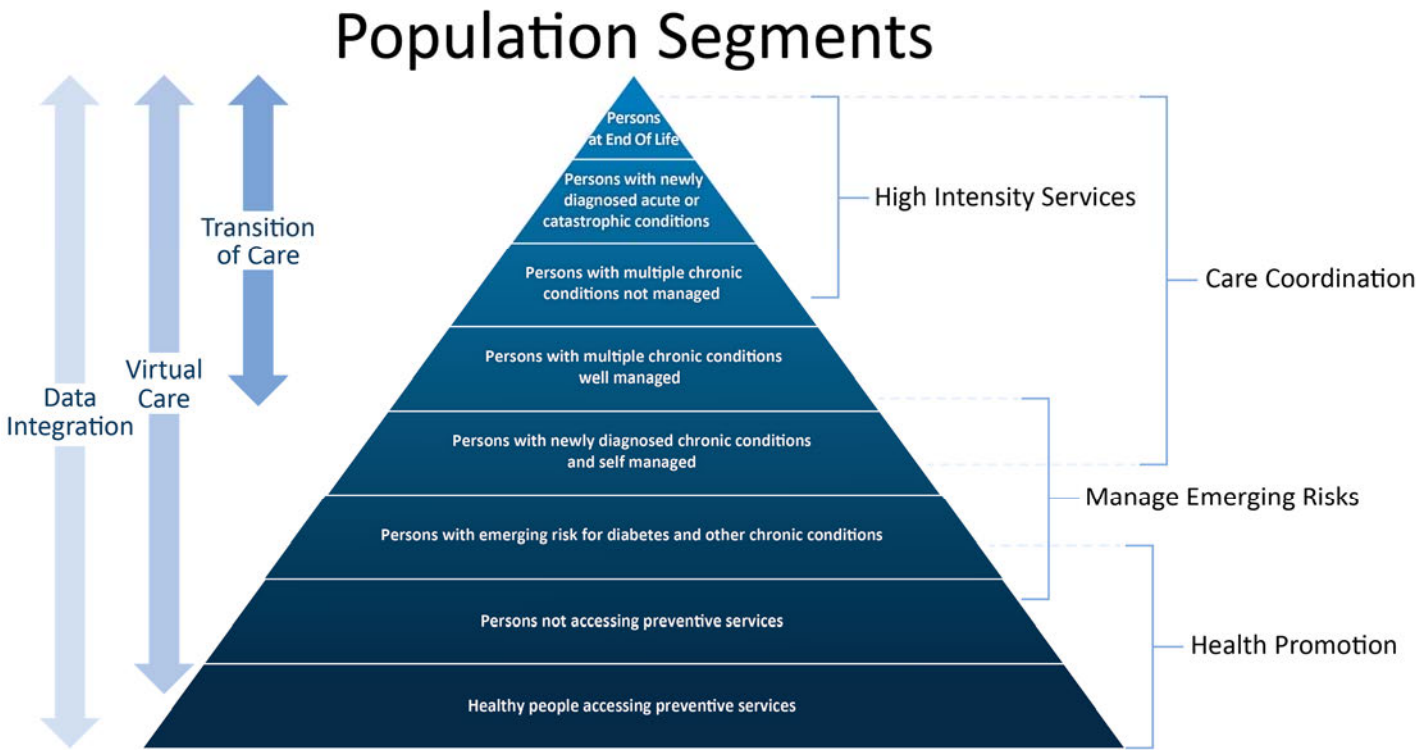
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions, and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2021 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2021 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2021–2022 Strategic goals.

1. Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.

2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.

3. Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0

These top three priority goals were chosen to be aligned with CalOptima's strategic objectives related to the pandemic, as well as continued goals related to access to care and NCQA Accreditation. The 2021 QI Workplan details the planned activities to meet the COVID-19 vaccine aim which include an immunization strategy, a targeted communication strategy and a member incentive strategy. The planned activities related to member's ability to access care are captured in the Virtual Care strategy as well as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). Finally, the goal of achieving NCQA-Accredited status in 2021 and maintaining the overall health plan rating is a high priority since CalOptima will be pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care for the OneCare and OneCare Connect programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact

- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima strategic priorities and the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Stars and Health Outcomes Survey (HOS) scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual patient care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2021 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2021 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.

- Measures required by regulators, such as DHCS and CMS.

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term services and supports, and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization. For example:

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.

- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.

- Project coordination occurs through the various leadership structures: Board of Directors, management, QIC, UMC, etc., based upon the scope of work and impact of the effort.

- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality Measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers or predictors of the desired outcome measures or lag quality measure, such as HEDIS and Stars measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized.

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forums, and other ongoing ad hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both website and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes, and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on CalOptima's website, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation, and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima CMO and ED, Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)

- Supervisor, Quality Improvement, and Master Trainer (FSR)
- Supervisor, Credentialing
- QI Nurse Specialists
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:
- Quality Analytics HEDIS Manager
- Quality Analytics Pay for Value Manager
- Quality Analytics Network Adequacy Manager
- Quality Analytics Data Analytics Manager
- Quality Analytics Analysts
- Quality Analytics Project Managers
- Quality Analytics Program Coordinators
- Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:
- Population Health Management Manager (Program Design)
- Population Health Management Manager (Operations)
- Population Health Management Supervisor (Operations)
- Health Education Manager
- Health Education Supervisor
- Population Health Management Health Coaches
- Senior Health Educator
- Health Educators
- Registered Dietitians
- Data Analyst
- Program Manager

- Program Specialists
- Program Assistant

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operations)
Provides clinical operational oversight and leadership to the implementation, expansion and/or improvement of processes and services of the Behavioral Health Integration department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and UM for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

Director, Utilization Management
Assists in the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective, and retrospective reviews that support UM medical management decisions, serves on the Utilization Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management (PM) program, develops, and implements PM department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the Pharmacy & Therapeutics Committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
Responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment,

collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics
Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the road map. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the Enterprise Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization, and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.

- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.

- An evaluation of member satisfaction surveys and initiatives.

- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.

- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, QAC, and the Board of Directors' review and approval.

Key Business Processes, Functions, Important Aspects Of Care And Service

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability

- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care, and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM and CM Programs and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities.
  - Drive improvement of quality of care received.
  - Minimize rework and unnecessary costs.

    - Measure the member experience of accessing and getting needed care.
    - Empower staff to be more effective.
    - Coordinate and communicate organizational information, both division and department-specific, as well as agencywide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements.

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima and delegated to HNs and other sub-delegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and re-credentialing of OPs such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free- standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care provider (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR, and physical accessibility review survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for pre-contracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with MMCD Policy Letter 14-004 and CalOptima policies. The Initial Medical Record Review shall be completed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that its contracted delegated HNs make certain that each member's medical record is maintained in an accurate manner that is current, detailed, organized and easily accessible to treating practitioners. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law.

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.

- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)

- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.

- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.
- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required.
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners.
- Facilitate satisfaction surveys for members.

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, Stars and HOS measures. This

information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2021 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services, and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source, and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection and analysis timelines
- Evaluation of re-measurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM programs**.** PHM programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members, and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management, Tobacco Cessation, Asthma, Immunizations, and Well Child Visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources, and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. A systemwide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner, and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of social determinates of health (SDOH). It proactively identifies those members in need of closer management, coordination, and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary

- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC, and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination, and basic are specific to SPD, OCC, and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
    - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
        - Roles and responsibilities of this team:
            - Basic case management, including advanced care planning
            - Medication reconciliation
            - Identification of member at risk of planned and unplanned transitions
            - Referral and coordination with specialists
            - Development and implementation of an ICP
            - Communication with members or their representatives, vendors, and medical group
            - Review and update the ICP at least annually, and when there is a change in the member's health status
            - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members

    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker

        - Roles and responsibilities of this team:

            - Identification and management of planned transitions
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services

- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization

- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at-high-risk individuals

- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.

- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC

In 2021, OC/OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician, or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2021 UM Program Description.

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved, and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture, and diverse needs

- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered

- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting

    - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    - Annual blood-borne pathogen and hazardous material training
    - Preventative maintenance contracts to promote keeping equipment in good working order
    - Fire, disaster, and evacuation plan, testing and annual training

- Institutional settings, including CBAS, SNF, and MSSP settings

    - Falls and other prevention programs
    - Identification and corrective action implemented to address post-operative complications
    - Sentinel events, critical incident identification, appropriate investigation, and remedial action
    - Administration of flu and pneumonia vaccines
    - COVID-19 Infection Prevention and Protective Equipment

- MRSA prevention program (Shield)

- Administrative offices

  - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact, 24-hour access to telephonic interpreter services, member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- OC member materials are provided in three languages: English, Spanish and Vietnamese.
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity

- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards).
- Behavioral Health for MC, OC, and OCC lines of business
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, and peer review process on specific, referred cases
- Development of system-wide measures, thresholds, and standards
- Satisfaction surveys of members, practitioners, and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and organizational providers (OPs)
- Credentialing and re-credentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards

- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2021 Delegation Grid.

See Appendix B — 2021 Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

Appendix A — 2021 QI Work Plan

APPENDIX B — 2021 DELEGATION GRID

APPENDIX C — ORGANIZATIONAL CHART

I. PROGRAM OVERSIGHT

A. 2021 QI Annual Oversight of Program and Work Plan
B. 2020 QI Program Evaluation
C. 2021 UM Program
D. 2020 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program updates (Health Network Quality Rating, MCAS, P4V)
M. Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC
N. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
O. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
P. Homeless Health Initiatives (HHI): Health Homes Program Phase 2
Q. Health Equity

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH)
B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

Emily Fonda, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Mary Giammona, MD Date:

C. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*, which is a NCQA Accreditation Measure
D. Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations
B Blood Lead Screening

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Timely Access (Appointment Availability)
C. Improve Access: Telephone Access
D. Improve Access: Virtual Care Strategies

VIII. QUALITY OF SERVICE- Member Engagement

A. Improve Member Experience- Member Engagement

IX. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing
C. Post-Acute Infection Prevention Quality Incentive (PIPQI)
D. Orange County COVID Nursing Home Prevention Program
E. LTC Facility Transfer Plan due to COVID-19

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT								
2021 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2021 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by February 2021	Esther Okajima				
2020 QI Program Evaluation	Complete Evaluation 2020 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by February 2021	Esther Okajima				
2021 UM Program	Obtain Board Approval of 2021 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by February 2021	Mike Shook				
2020 UM Program Evaluation	Complete Evaluation of 2020 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by February 2021	Mike Shook				
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Pshyra Jones				
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima				
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Ana Aranda				
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook				
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD				
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital				
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, Collaboration with OC Coalition of Clinics to receive their aggregated EMR data, efforts to immunization registry (CA R) and lab data gaps (Blood Lead Testing results for example) Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital				
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn				

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achive program milestones quarterly and annual performance goals	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Quarterly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Quarterly Adoption of Report	Edwin Poon				
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COV D-19	Quarterly Report	Sloane Petrillo				
Homeless Health Initiatives (HHI): Health Homes Program Phase 2	Improve Health & Access to care for enrolled members	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI 5. Focus on telephonic outreach d/t COV D-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Quarterly Report	Sloane Petrillo				
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Pshyra Jones/Marie Jennis				
II. QUALITY OF CLINICAL CARE- Adult Wellness								
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	**MY2020 Goal** **CCS -** MC 61 31% **COL** - OCC 73% OC 62% **BCS** - MC 58.82% OCC - 76% OC - 76%	1) Continue $25 member incentive program for completing a CCS. 2) Targeted member engagement and outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Targeted member engagement and outreach campaigns to promote colorectal cancer screenings in coordination with health network partners 4) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted member engagement outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Coordinate mobile mammography clinics in zip codes with low incidence of screening. 4) Track the number of mammograms scheduled through targeted outreach. 5) Member Health Rewards RFP and Vendor Contract	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 70% or more of CalOptima members (16 and over).	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COV D vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a.They are now eligible to be vaccinated. b.Where they need to go to be vaccinated (when available) c.This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				
III. QUALITY OF CLINICAL CARE- Behavioral Health								
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2020 Goal** 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC NA;OCC:18 20%	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	12/31/2021	Edwin Poon	Yes			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**MY2020 Goal** MC - Init Phase - 42.92% MC - Cont Phase - 54.73%	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	12/31/2021	Edwin Poon	Yes			
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS MY2020 Goal MC NA**	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	12/31/2021	Edwin Poon	Yes			
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal** MC 38.18% OC 56% OCC 56%	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	12/31/2021	Edwin Poon	Yes			

2021 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE- Chronic Conditions								
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**HEDIS MY2020 Goal (A1C Poor Control)** MC 37.47% OC: 19.46% OCC: 19.46%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Targeted member engagement and outreach campaigns to promote Diabetes A1C testing in coordination with health network partners 3) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS MY2020 Goal (Diabetic Eye Exams)** MC: 58.64% OC: 67.5% OCC: 67.5%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Targeted member engagement and outreach campaigns to promote Diabetes Eye Exam in coordination with health network partners 5) Member Health Rewards RFP and Vendor Contract 6) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 7) Prop 56 provider value based payments for diabetes care measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
V. QUALITY OF CLINICAL CARE- Maternal Child Health								
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	**HEDIS MY2020 Goal** Prenatal 89 05% Postpartum 76.40%	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Implement Collaborative Member Engagement Event with OC Diaper Bank (3-4 times yearly) 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	12/31/2021	Ann Mino	Yes			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness								
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	**HEDIS MY2020 Goal** MC 65 83%	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents; and track the number of participants for targeted adolescent "Back-to-School" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung	Yes			
Blood Lead Screening	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2020 Goal**: Lead Screening 50th percentile 73.11%	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials 4)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 5) Prop 56 provider value based payments for Blood Lead Screening	12/31/2021	Pshyra Jones/ Helen Syn/ Mimi Cheung				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access								
Improve Access: Reducing gaps in provider network	Contract with a minimum of 25% of targeted providers identified by the network adequacy work group.	1) Actively recruit hard to access specialties for CCN	12/31/2021	Michelle Laughlin/Jennifer Bamberg				
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists by 10 percentage points.	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After All Attempts** from 28.3% to 25.0%	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	12/31/2021	Marsha Choo/Jennifer Bamberg				
Improve Access: Virtual Care Strategies	Increase telehealth utilization rate from 24.1% to 30% (visit count/# members) Increase member telehealth usage from 8.8% to 10% (teleheatlh member count/# members)	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	12/31/2021	Marsha Choo/Rick Cabral				
VIII. QUALITY OF SERVICE- Member Engagement								
Improve Member Experience: Member Engagement	Increase member engagement via member portal.	1) Member Portal 2) Member Outreach Calls	12/31/2021	Mauricio Flores/Andrew Tse				
IX. SAFETY OF CLINICAL CARE								
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	HEDIS MY2020 Goal: MC - NA OC 8%; OCC 0 85 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	12/31/2021	Mike Shook	Yes			
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	Provide clinical recommendations to members with a quality of care grievance within 30 days.	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	12/31/2021	Laura Guest/Ana Aranda				

2021 QI Work Plan Element Description	**Goals**	**Planned Activities**	**Target Date(s) for Completion**	**Staff Responsible**	Con't Monitoring from previous year	**Results/Metrics Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Post-Acute Infection Prevention Quality Incentive (P PQI)	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer lodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2021	Cathy Osborn/Scott Robinson	Yes			
Orange County COV D Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COV D/Infections in nursing facilities	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COV D-19 as soon as possible 2) Provide expertise on infection prevention for COV D-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COV D 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www ucihealth org/stopcovid	5/31/2021	Cathy Osborn/Scott Robinson				
LTC Facility Transfer Plan due to COVID-19	Transfer 100% of CalOptima members to other facilities within 5 days of evacuation notice.	1) Train all LTSS staff in LTC operational DTP: LTC015 LTC facilities planned and unplanned closure process. 2) Monitor all nursing facilities for COVID_19 positive rates in members and facility staff 3) Identify high-risk facilities that hae COV D-19 related staffing shortages and high infection rates that my require evacuation. 4) Identify and maintain a log of available nursing facility beds that members could be transferred to.	12/31/2021	Scott Robinson				

APPENDIX B — 2021 DELEGATION GRID

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.2.4	PHM2D: Segmentation-PHM	X		X	
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X		X	
3.4.2	NET4B: Continued Access to Practitioners	X		X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA for Interim Surveys only
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				NA for Medicaid
4.9.6	UM9F: Appeals Overturned by the IRO				NA for Medicaid
4.9.7	Provider Appeals Provider Complaint Processing	X	X	X	
4.10.1	UM10A: Written Process				NA for Medicaid
4.10.2	UM10B: Description of the evaluation Process				NA for Medicaid
4.11.1	UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X	
4.11.2	UM11B: Pharmaceutical Restrictions/Preferences	X		X	
4.11.3	UM11C: Pharmaceutical Patient Safety Issues	X		X	
4.11.4	UM11D: Reviewing and Updating Procedures	X		X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.11.5	UM11E: Considering Exceptions	X		X	
4.12.1	UM12A: UM Denial System Controls	X	X	X	
4.12.2	UM12B: UM Appeal System Controls	X		X	
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				NA due to Carve out
5.7.4	CR7D: Assessing Medical Providers	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.5	CR7E: Assessing Medical Providers				NA due to Carve out
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations				NA for Medicaid
6.3.2	ME3B: Communication with Prospective Members				NA for Medicaid
6.3.3	ME3C: Assessing Member Understanding				NA for Medicaid
6.4.1	ME4A: Functionality: Website	X		X	Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X		X	Not Required for Renewal Survey

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			May not be Delegated
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Claims Processing Timeliness of Claims and Interest on Late Claims	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR)	X	X	X	

Back to Agenda Back to Item

2021 QI Program Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
7.1.7	Third Party Liability (TPL) CalOptima policy FF.2007: Reporting of Potential Third-Party Liability.	X	X	X	
7.1.8	Family Planning Services CalOptima Policy GG.1118: Family Planning Services, Out-of-Network	X	X	X	

Note: NCQA Elements are based on current 2020 HP Standards.

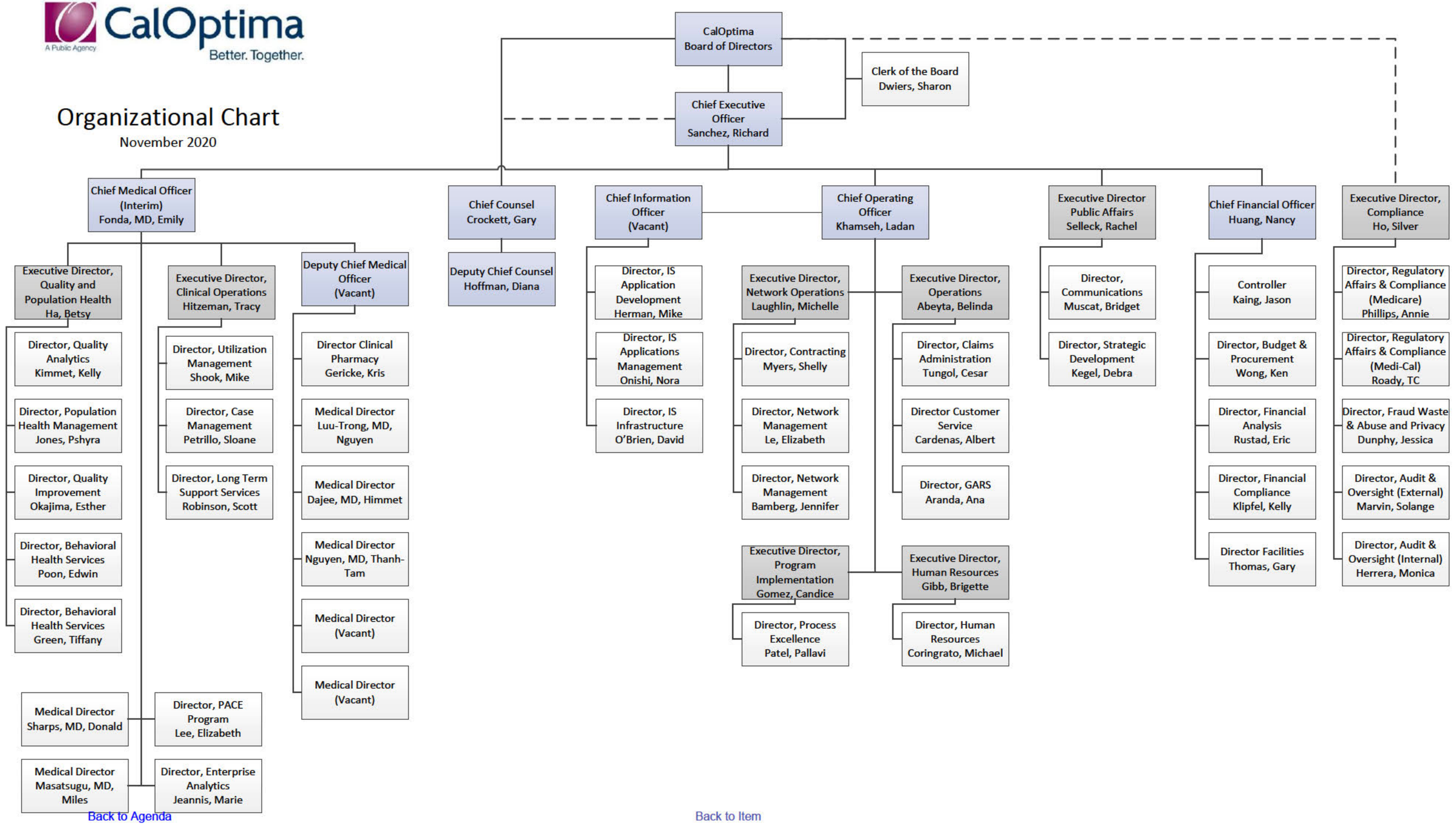
Back to Agenda Back to Item

APPENDIX C — ORGANIZATIONAL CHART

CalOptima
A Public Agency
Better. Together.

Organizational Chart

November 2020



Back to Agenda

Back to Item

Updated Quality Improvement (QI) Program Evaluation Recommendations and Updated 2021 QI Workplan

Board of Directors Meeting

April 1, 2021

Esther Okajima, Director, Quality Improvement

Pshyra Jones, Director, Population Health Management

Back to Agenda

Back to Item

Agenda

- Quality Improvement (QI) Program: Overview
- 2021 QI Program Recommendations
- 2021 Quality Initiatives

Back to Agenda

Back to Item

CalOptima
A Public Agency

QI Program: Overview

- The purpose of the QI program is to establish a systematic process for evaluating and improving quality outcomes in accordance with regulatory and accreditation requirements.
- Annually, CalOptima evaluates the effectiveness of the QI Program including:
  - Program structure
  - HEDIS outcomes
  - Population analysis
  - New initiatives and programs
- Based upon the evaluation, the program is revised and updated for the following year.

2021 QI Program Recommendations

- Continue member “health rewards” to increase member engagement for preventive care gaps.
- Intensify targeted member outreach.
- Continue to utilize P4V to drive improvement.
- Implement Behavioral Health P4V program.
- Prioritize Data Bridge Efforts.
- Expand Virtual Care Strategy.
- Continue to sponsor the Orange County Nursing Home COVID Prevention Program in partnership with UCI’s Epidemiology Team.
- Continue to sponsor, train, and incentivize the Post-Acute Infection Prevention Quality Incentive (PIPQI) — the only program in the nation

2021 Quality Initiatives

- Member “health reward” programs to increase member engagement for preventive care gaps:
  - Immunizations (Flu and COVID Vaccinations)
  - Annual Wellness Visit
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Diabetes Eye Exam
  - Diabetes A1c Test
  - Postpartum Care
- Intensify member outreach and engagement utilizing various member engagement strategies.

2021 Quality Initiatives

- On-site member engagement outreach events:
  - Back to School Wellness Adolescent Health Immunization Clinic
    - Potentially to include COVID-19 Vaccines when available
  - Mobile Mammography Clinic
  - OC Diaper Bank (new)
  - Great American Smokeout per American Cancer Society
  - Shape Your Life Childhood Obesity Prevention Community Classes
- Implement multidisciplinary approach to improving Diabetes Care Program for Medi-Cal CalOptima Community Network (CCN) members.

Our Mission

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

Back to Agenda

Back to Item

CalOptima
A Public Agency

Board of Directors Meeting
April 1, 2021

Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Board Report

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On March 11, 2021, 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) held a special joint meeting to discuss topics of mutual interest.

Richard Sanchez, Chief Executive Officer, updated the members on the current status of COVID-19 and the vaccination efforts that are ongoing. He noted that the Third Party Administrator (TPA) for the COVID vaccines had changed to Blue Shield for the State of California. Mr. Sanchez also briefly discussed the CalAIM submission that CalOptima plans to submit by July 2021.

Emily Fonda, M.D., Interim Chief Medical Officer, updated the committees on the current COVID-19 pandemic and discussed the vaccine incentives roll-out, with an emphasis on the homeless population.

Rachel Selleck, Executive Director, Public Affairs, and Debra Kegel, Director, Strategic Development, discussed CalOptima's Strategic Plan update and the directive from the Board to the Committees. Ms. Selleck introduced Athena Chapman and Caroline Davis of Chapman Consulting, who facilitated a session with the committee members in attendance on four initiatives: Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health. Committee members participated in a question and answer dialogue on all four initiatives. Both MAC and PAC will again review the initiatives at their respective April 8, 2021 meetings.

Helene Calvet, M.D., Deputy Medical Director, Orange County Health Care Agency, and Patty Mouton, Vice President, Alzheimer's Orange County and MAC member and OCC MAC chair, presented on how the OCHCA and Alzheimer's Orange County worked together to open a COVID care unit at the Fairview Developmental Center in Costa Mesa to treat seniors with Alzheimer's and other related dementia who test positive for COVID-19.

The committees also received a CalAIM update and a Federal and State Legislative update.

The members of the MAC, OCC MAC, PAC, and WCM FAC appreciate the opportunity to update the Board on their current activities.

Back to Agenda

Board of Directors Meeting
April 1, 2021

Whole-Child Model Family Advisory Committee (WCM FAC) Update

At the February 23, 2021 Whole-Child Model Member Family Advisory Committee (WCM FAC) meeting, members received an update from Richard Sanchez, Chief Executive Officer, on another delay of the Medi-Cal Rx transition by the Department of Health Care Services. He also informed the committee that Nancy Shivers had been selected as the new Member Representative on the Board and will begin her term on March 4, 2021.

Committee members received verbal updates from Tracy Hitzeman, Executive Director, Clinical Operations, on DHCS's California Children Services Advisory Group (CCS AG) January meeting and on durable medical equipment (DME) repairs.

Thanh-Tam Nguyen, M.D., Medical Director, introduced Mindy Winterswyck, Division Manager/Chief of the Medical Therapy Program for California Children Services (CCS) with the Orange County Health Care Agency. Ms. Winterswyck discussed and answered questions on the County's Medical Therapy Program.

Kristin Gericke, Director, Pharmacy Management, provided an update on the indefinite delay by DHCS of the Medi-Cal Rx transition to Magellan Health Care.

The Committee also received an updated from Emily Fonda, M.D., Interim Chief Medical Officer, on COVID-19 and E-Consults/Telehealth visits. Jackie Mark, Sr. Policy Advisor, Government Affairs, provided the Committee with a Federal and State Legislative update.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

Back to Agenda