NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MAY 7, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

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

INTERIM 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(s) identifying the item(s) and submit to the Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

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

The Board Meeting Agenda and supporting 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 (914) 614-3221 Access Code: 929-836-906 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/8234686450807907 98
3) **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

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.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. CalOptima Response to COVID-19
   b. Behavioral Health Integration Incentive Program
   c. Medi-Cal Audit

CONSENT CALENDAR
2. Minutes
   a. Consider Approving Minutes of the April 2, 2020 Regular Meeting of the CalOptima Board of Directors; and the Minutes of the April 16, 2020 Special Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 27, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

REPORT ITEMS
3. Consider Approval of New CalOptima Policy AA.1500: Medical Respite Program and Authorization of Related Amendment of the County Coordination and Provision of the Public Health Care Services Contract

4. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

5. Consider Approval of CalOptima's New FQHC/RHC Pay for Performance Policy and Modified Quality Improvement Policies

6. Consider Actions Related to CalOptima's Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers Contracted with the CalOptima Community Network for the OneCare Connect Program

7. Consider Actions Related to Support Orange County Nursing Facilities During the Coronavirus (COVID-19) Pandemic

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

9. Consider Authorizing Contracts and Funding to Support the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Response to COVID-19

10. Authorize Amendment to Medi-Cal Ancillary Contracts for Skilled Nursing Facilities

11. Consider Approval of Resolution Renaming Seats on the CalOptima Board of Directors' Member Advisory Committee

12. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment

13. Consider Recommendations for Expenditures Previously Approved Towards Support of CalOptima's Participation in Community Events Impacted Due to COVID-19 Pandemic

14. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2021 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement (to follow Closed Session)

15. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2021 and Execute Three-way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement (to follow Closed Session)

ADVISORY COMMITTEE UPDATES

16. Joint Member Advisory Committee and Provider Advisory Committee Update

INFORMATION ITEMS

17. Introduction to the FY 2020-21 CalOptima Budget:

18. March 2020 Financial Summary

19. Compliance Report

20. Federal and State Legislative Advocates Reports

21. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare and OneCare Connect

ADJOURNMENT

Webinar Instructions for Joining the Regular Meeting of the CalOptima Board of Directors
May 7, 2020 at 2:00 p.m.

1. **Please register for the Regular Meeting of the CalOptima Board of Directors occurring on Thursday, May 7, 2020 at 2:00 PM PDT at:**
   https://attendee.gotowebinar.com/register/8234686450807907 98

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 (914) 614-3221
   Access Code: 929-836-906
   Audio PIN: Shown after joining the webinar

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MEMORANDUM

DATE:	April 28, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — May 7, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Coronavirus Disease-19 (COVID-19) Crisis Drives CalOptima Action Across Many Fronts
CalOptima's primary focus remains a comprehensive yet flexible COVID-19 response that considers the needs of members, providers, stakeholders and employees. As of April 28, Orange County had 2,151 COVID-19 cases, and 229 have been reported as CalOptima members. Below are a range of updates.

- *Governor's Executive Order and All-Plan Letter:* On April 22, Gov. Gavin Newsom issued an Executive Order that provides flexibility in state regulations so the Department of Health Care Services (DHCS) can take appropriate actions to mitigate the pandemic's effects on Medi-Cal managed care plans, including CalOptima. In response, DHCS issued an All-Plan Letter on April 24 with temporary changes in three areas:
  1. Site Reviews and Delegate Monitoring: DHCS is permitting managed care plans to temporarily suspend the contractual requirement for in-person site reviews, and medical audits of delegates and network providers. DHCS suggests the use of virtual alternatives until future guidance permits on-site verification.
  2. Audits: Annual DHCS medical audits are suspended due to COVID-19; however, all managed care plans must comply with currently imposed Corrective Action Plan requirements and milestones.
  3. Health Risk Assessments (HRAs): DHCS is extending the timeframes allowed for completing HRA surveys for newly enrolled Seniors and Persons with Disabilities to ensure that staff time and resources are directed to urgent needs. For the duration of the public health emergency, CalOptima must conduct HRAs within 135 days of enrollment for high-risk members and 195 days for lower-risk members. HRAs can be completed by phone or video conference.
- *Skilled Nursing Facilities (SNFs):* CalOptima is protecting vulnerable SNF residents by addressing COVID-19 outbreaks and launching a new infection prevention program. As of this writing, a small percentage of CalOptima's 67 contracted SNFs have members who are positive for COVID-19. CalOptima is coordinating response with the Orange County Health Care Agency (OCHCA), which has visited certain impacted facilities along with the California Department of Public Health (CDPH) to review infection control best practices and provide testing. With Board approval on April 2, CalOptima is now expanding the Post-Acute Infection Prevention Quality Initiative (PIPQI) to more SNFs. PIPQI uses Chlorhexidine soap instead of regular soap for bathing nursing home residents in conjunction with the use of Iodophor nasal swabs. While PIPQI is focused on lowering the incidence of

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Multi-Drug Resistant Organisms, such as MRSA, coronaviruses are also highly sensitive to Chlorhexidine. Further, CalOptima has implemented a new collaborative effort with OCHCA and UC Irvine, the Nursing Home COVID-19 Prevention Team protocol, which disseminates infection prevention strategies to contracted SNFs. Developed by UCI Infectious Disease Professor Susan Huang, M.D., the protocol includes refresher training for safe personal protective equipment (PPE) use along with recommendations for widespread testing for the presence of virus and antibodies in both patients and staff. Because prevention is especially important prior to the availability of a vaccine, the training sessions and oversight will be ongoing during the next year. This project will operate alongside PIPQI and any OCHCA rapid response efforts being conducted at individual facilities. Finally, and separately, the Centers for Medicare & Medicaid Services (CMS) announced on April 20 new regulatory requirements for SNFs to inform residents and their families of COVID-19 cases and to report data at the federal level directly to the Centers for Disease Control and Prevention.

- *Testing:* COVID-19 testing is separated into molecular tests for diagnosis as well as serologic tests for the presence of antibodies. To increase diagnostic test availability locally, Orange County announced the OC COVID-19 Testing Network with six sites launched at present. CalOptima is updating our guidance about how to access testing to include the new OC COVID-19 Testing Network and will be sharing information with members and providers. However, for continuity of care, members should try to access tests through their providers or health network first before using this new testing network. CalOptima continues to meet with the County to discuss how serologic testing fits into the overall testing strategy. Given the critical importance of both tests in reopening our community, CalOptima will continue to actively collaborate on a comprehensive testing strategy for Orange County, with the County as lead.
- *Providers and Health Networks:* CalOptima distributes frequent communications to contracted providers and health networks via website updates and fax blasts. Staff reorganized the website to highlight links to those agencies at the center of the COVID-19 response, including CMS, CDPH, DHCS and OCHCA. Also, because telehealth is essential at this time, we collected telehealth resources into one area on the website for ease of use.
- *Community Updates:* CalOptima is sharing COVID-19 information and resources with hundreds of community-based organizations via a weekly electronic newsletter, which can also be accessed online here.
- *All-Member Call Campaign:* Our Population Health Team developed a COVID-19 message for all CalOptima members and will complete an interactive voice response call campaign in early May. The message covers preventive measures, symptoms and high-risk groups, then closes with the recommendation that members seeking health advice should call their doctor or health network first, or our 24-hour Nurse Advice Line if those other contacts are not available.
- *Senior Outreach:* A recent DHCS All-Plan Letter issued requirements for health plans to work to prevent isolation in older and at-risk populations and to support them with health and community resources. OneCare Connect and OneCare Customer Service staff began an outreach call campaign in mid-April. Thus far, more than 450 members have been contacted, and several common issues emerged. The members were generally thankful for the inquiry about their well-being during COVID-19. Members also confirmed that they have not encountered access issues with obtaining health services via telehealth. Some members were

assisted with customer service-type needs during their conversation, such as accessing vision care or locating a pharmacy with home delivery.

- *Awareness Campaign:* From May 4 to June 28, digital billboards along the 5, 22, 57 and 91 freeways will show timely COVID-19 messages as part of CalOptima's overall awareness campaign. Our Population Health Management and Communications teams developed the material to ensure our campaign reflects the current health care environment.
- *Community Health Centers:* On April 17, CalOptima staff and I participated in a virtual meeting of the quarterly Safety Net Summit, which brings together members of the Coalition of Orange County Community Health Centers. Like other parts of the health care delivery system, community health centers are facing great operational and financial difficulties in the COVID-19 crisis and would like to explore partnering with CalOptima for additional support. Coalition CEO Isabel Becerra and I had a discussion regarding options, and I agreed to continue the conversation as the situation evolves.
- *Hospital Payments:* Significant revenue losses and cash flow problems at hospitals across the state spurred two letters: one from the California Hospital Association to Gov. Newsom and another from a group of hospital organizations to DHCS. Both communications requested funding and regulatory adjustments to ensure hospital system solvency in the future. CalOptima's hospital partners shared copies of the letters as they include certain requests of managed care plans, including to resolve unpaid claims, make advance payments and remove administrative barriers to payments. While DHCS is looking into programs to provide broad support to hospitals, CalOptima is working on accelerating hospital claims payment. Our goal is to pay 97% of claims within 30 days. Similarly, we have contacted health networks that have contracted relationships with hospitals to request that they also expedite payment.
- *Intergovernmental Transfer (IGT) Community Grants:* This past year, your Board authorized community grants using IGT 5, 6 and 7 funds. Twelve grants were approved for 11 grantees, with one organization receiving grants in two different funding categories. Due to California's Stay at Home Order and regulatory guidance, most of the IGT grantees have had to curtail grant activities on new initiatives in order to focus on the immediate crisis. Staff has contacted grantees to discuss requests they may have to mitigate the impact of COVID-19, such as workplan modifications, budget adjustments, grant extensions or modified reporting requirements. Staff will return to your Board for approval of any necessary grant contract modifications.
- *Opening Up Health Care:* Orange County providers have limited nonessential surgeries and medical procedures during the COVID-19 crisis. However, on April 20, CMS issued new recommendations for health care services in communities beginning to reopen. CMS recommends a gradual transition into restarting or increasing in-person care that is coordinated with local and state public health officials, and considers PPE supplies, workforce availability and facility readiness. CMS aims to give health care facilities some flexibility in providing essential non-COVID-19 care to patients without COVID-19 symptoms. CalOptima shared the new guidelines with our provider partners and will incorporate the recommendations into our overall response efforts.
- *Employees:* CalOptima is exempted from the governor's Stay at Home Order based on our role in health care. However, to respond to social distancing mandates, CalOptima has transitioned most staff to temporary telework status. As of April 24, 87% of CalOptima's 1,379 employees are working from home. To provide support for leaders now managing

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teleworkers, CalOptima hosted a series of three webinars presented by an experienced speaker/consultant who shared practical strategies for boosting productivity and engagement in team members working remotely.

Timeline Shifts for Behavioral Health Integration (BHI) Incentive Programs
As you know, DHCS created six BHI incentive programs using Proposition 56 funds and tasked Medi-Cal managed care plans with administering the application process and applying DHCS-developed selection criteria. Of the 30 applications CalOptima received, 17 applications met the DHCS requirement and were forwarded to the state for consideration. On March 30, DHCS announced that program implementation will be moved to July 1, 2020, with determination letters being issued no later than June 1, 2020. The program will be adjusted to a new 2.5-year period, from July 1, 2020, to December 31, 2022. Additionally, funding requests for the first year (July 1, 2020, to December 31, 2020) will be adjusted to reflect the shortened program period.

CalOptima's 2020 Medi-Cal Audit Scope Adjusted Again
DHCS' on-site audit of CalOptima Medi-Cal and elements of OneCare Connect took place from January 27, 2020, to February 7, 2020. The regulator reviewed an array of documents and data and conducted interviews with CalOptima staff and a DHCS-selected delegate, Monarch HealthCare. On February 12, the state notified CalOptima that, in response to a request from DHCS leadership, it planned to add to the Medi-Cal audit scope by reviewing authorization practices related to post-stabilization care. In addition to auditing CalOptima's practices, DHCS asked to examine the practices of two CalOptima delegates, Prospect Medical Group and Family Choice Medical Group. CalOptima prepared and submitted the requested data and documentation throughout March. However, on April 24, DHCS notified CalOptima that it decided not to include the post-stabilization authorization review in the audit scope due to COVID-19. CalOptima is awaiting an audit exit conference in the coming weeks.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

April 2, 2020

A Regular Meeting of the CalOptima Board of Directors was held on April 2, 2020 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 Paul Yost, M.D., called the meeting to order at 2:01 p.m. Chief Executive Officer Michael Schrader led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger; Ron DiLuigi; Supervisor Andrew Do; Alexander Nguyen, M.D.; Lee Penrose; Richard Sanchez (non-voting); Scott Schoeffel; Supervisor Michelle Steel (All members at teleconference locations except the Chair)

Members Absent: None

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

Chair Yost announced that today is Michael Schrader's last regular CalOptima Board meeting and wished him all the best in his future endeavors. On behalf of the CalOptima Board, Chair Yost presented Mr. Schrader with a CalOptima "rock" and thanked him for his service to CalOptima and its members.

Chair Yost also noted that he was reordering the agenda to hear Agenda Items 31 and 36 just before the Consent Calendar, and Information Item 33 just before Agenda Item 26.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Chief Executive Officer (CEO) Michael Schrader highlighted items in his report regarding COVID-19.

PUBLIC COMMENTS

There were no requests for public comment.

INFORMATION ITEMS

31. COVID-19 Update

David Ramirez, M.D., Chief Medical Officer, provided an update on CalOptima's activities related to

the Coronavirus pandemic.

36. Federal and State Legislative Advocates Reports

Joshua Teitelbaum and Eli Tomar, CalOptima's lobbyists from Akin Gump Hauer & Strauss LLP in Washington, D.C., provided an update on the latest actions at the federal level with regard to COVID-19, including the CARES Act and 1135 Waiver provisions.

CONSENT CALENDAR

2. Minutes

a. Consider Approving Minutes of the March 5, 2020 Regular Meeting of the CalOptima Board of Directors; the March 12, 2020 Special Meeting of the CalOptima Board of Directors; and the March 23, 2020 Special Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the August 8, 2019 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee; the October 10, 2019 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee; Provider Advisory Committee, Whole-Child Model Family Advisory Committee; and the October 24, 2019 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 9-0-0)***

REPORT ITEMS

3. Consider Ratification of Actions Taken in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized ratification of the implementation of mitigation strategies to slow the transmission of COVID-19 through temporary telework for CalOptima employees; and ratification of unbudgeted expenditures from existing reserves for emergency purchases to support these mitigation strategies, including CalOptima's Temporary Telework process in the amount not to exceed $915,000. (Motion carried 9-0-0)***

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

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

Staff asked that recommended action #4 be removed in light of the California Department of the Health Care Services adopting a Medi-Cal rate for Coronavirus testing.

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Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors approved the amended action to 1.) Authorized Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020; 2.) Authorized waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect; 3.) Authorized unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates; ~~4.) Authorized interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020~~ and 5.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to: a.) Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and b.) Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application. (Motion carried 5-1-1; Supervisor Steel voting no; Supervisor Do abstained; Director Schoeffel and Chair Yost recused)*** Amended 4/2/2020

5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Betsy Ha, Executive Director, Quality and Population Health Management, introduced the item and responded to questions from the Board.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1.) Ratified 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.) Ratified contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy; 3.) Ratified contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and 4.) Authorized reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants. (Motion carried 8-0-0; Director Schoeffel recused)***

6. Consider Authorizing Amendment to the County of Orange Public Healthcare Services Contract, for the Provision of Targeted Engagement and Housing Supportive Services
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Sanchez did not participate in this item due to his position with the Orange County Health Care Agency.

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Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1.) Authorized CalOptima's Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima 's Public Healthcare Services Contract with the County of Orange to include reimbursement for: a.) Targeted engagement services for the Health Homes Program (HHP) which are not provided under or duplicative of the County's Whole Person Care (WPC) program for CalOptima Direct (COD) and CalOptima Community Network (CCN) Medi-Cal members eligible for the HHP enrolled with WPC and already receiving services from County's WPC program; b.) Continuation of payment for housing supportive services for those CalOptima Direct (COD) and CCN Medi-Cal members receiving housing supportive services through the WPC program at the time of enrollment into the HHP, subject to the requirement that the County cannot receive payment for such services from DHCS under the WPC program; and 2.) Authorized unbudgeted expenditures from existing reserves of up to $56,000 to provide funding for targeted engagement services and housing supportive services through June 30, 2020. (Motion carried 8-0-0; Director Schoeffel and Director Sanchez recused)***

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

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

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors 1.) Approved CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance; 2.) Authorized the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011; 3.) Authorized the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011; and 4.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)***

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8. Consider Authorizing a Contract with an Additional Community-Based Adult Service (CBAS) Provider to Serve as an Alternative Care Setting (ACS) for CalOptima Program of All-Inclusive Care for the Elderly (PACE) Members and Authorizing the Chief Executive Officer to Negotiate Rates for ACS Contracts

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1). Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to, effective May 1, 2020: a.) Contract with CBAS Provider Alzheimer's Family Center as an Alternative Care Setting (ACS) for CalOptima PACE members; and b.) Establish PACE ACS rates 5% higher than the CalOptima Community-Based Adult Services rate for PACE; and 2.) Authorized unbudgeted expenditures from existing reserves of up to $9,500 to provide funding for the ACS rate increase from May 1, 2020 through June 30, 2020. (Motion carried 8-0-0; Director Schoeffel recused)***

9. Consider Authorizing an Amendment to the Contract with Program of All-Inclusive Care for the Elderly (PACE) Transportation Provider Secure Transportation to Extend the Contract

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors Authorized CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current agreement for PACE transportation services with Secure Transportation for two years, effective June 1, 2020 through May 31, 2022. (Motion carried 8-0-0; Director Schoeffel recused)***

10. Consider Actions Related to the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts through June 30, 2021, under the same terms and conditions. (Motion carried 6-0-1; Supervisor Do abstained; Director Penrose and Director Schoeffel recused)***

11. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated with Children's Hospital of Orange County, the University of California, Irvine and St. Joseph Health and its Affiliates

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts under the same terms and conditions through June 30, 2021 except those associated with Children's Hospital of Orange County, the University of California, Irvine or St. Joseph Health and its Affiliates. (Motion carried 6-0-1; Supervisor Do abstained; Supervisor Steel and Director Schoeffel recused)***

12. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with the University of California, Irvine

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021. (Motion carried 6-0-1; Supervisor Do abstained; Supervisor Steel and Director Schoeffel recused)***

13. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with St. Joseph Health and its Affiliates

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with St. Joseph Health and its Affiliates, under the same terms and conditions through June 30, 2021. (Motion carried 5-0-1;***

Supervisor Do abstained; Chair Yost, Director Penrose and Director Schoeffel recused)

14. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County

Director Schoeffel did not participate in this item due to potential conflicts of interest. Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with Children's Hospital of Orange County (CHOC) under the same terms and conditions through June 30, 2021. (Motion carried 7-0-0; Chair Yost and Director Schoeffel recused)***

15. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated with the University of California, Irvine, or St. Joseph Healthcare and its Affiliates

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts under the same terms and conditions through June 30, 2021, except those associated with the University of California, Irvine, or St. Joseph Healthcare and its affiliates. (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)***

16. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with the University of California, Irvine

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021. (Motion carried 8-0-0; Director Schoeffel recused)***

17. Consider Actions Related to the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated with St. Joseph Healthcare and its Affiliates

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Director Schoeffel did not participate in this item due to potential conflicts of interest. Director DiLuigi did not participate in this item due to his affiliation with St. Jude Clinic. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health.

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts associated with St. Joseph Healthcare and its Affiliates, under the same terms and conditions through June 30, 2021. (Motion carried 6-0-0; Director DiLuigi, Director Penrose and Director Schoeffel recused)***

18. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts, Except Those Associated with the University of California, Irvine or St. Joseph Healthcare and its Affiliates

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts under the same terms and conditions through June 30, 2021, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates. (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)***

19. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with St. Joseph Healthcare and its Affiliates

Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts associated with St. Joseph Healthcare and its Affiliates under the same terms and conditions through June 30, 2021. (Motion carried 6-0-1; Supervisor Do abstained; Director Penrose and Director Schoeffel recused)***

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20. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-for-Service Primary Care Physician Contracts Associated with the University of California, Irvine

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care Physician (PCP) contracts associated with the University of California, Irvine, under the same terms and conditions through June 30, 2021 (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)***

21. Consider Actions Related to the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts and contracts with MedImpact Healthcare Systems, Inc. and Vision Service Plan

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

It was noted that action was taken on MedImpact at a previous meeting and should not be included in this motion. The Board amended the motion to remove MedImpact in the action below.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors approved the amended action to Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services contracts and contracts with ~~MedImpact Healthcare Systems, Inc. (MedImpact) and~~ Vision Service Plan (VSP), through June 30, 2021 under the same terms and conditions (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel recused)*** Amended 4/2/2020

22. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policy

Brigette Gibb, Executive Director of Human Resources introduced this item, noting that the revisions to Policy GA.8042 relate to the ability of the CEO to offer retention incentives to staff. The current policy allows for the CEO to offer up to 12 employee retention incentives, on a calendar year basis and in an amount not to exceed 10% of an employee's annual salary. The proposed revisions to this policy increase the annual number of retention incentives from 12 to 25, changes the relevant measuring period from a calendar year to fiscal year and increases the maximum amount from 10 % to 20%.

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No Action Taken: ***After considerable discussion, Supervisor Do made a motion, to defer this item until after April 6th when the Interim CEO would be starting. A roll call vote was taken. (Motion failed, Chair Yost, Dr. Khatibi, Director Berger, Director DiLuigi and Director Penrose voting no; Supervisor Do, Director Nguyen, Director Schoeffel and Supervisor Steel voting yes.)***

After further discussion, the Board concluded that the staff recommendation could be a valuable tool during this time of leadership change at CalOptima. The Board took the amended motion to allow only the Interim CEO or future permanent CEO to offer retention incentives as described in the revised policy.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors Adopted Resolution approving updates to CalOptima Human Resources Policy GA.8042: Supplemental Compensation (Motion carried 9-0-0)***

23. Consider Approval of an Executive Employment Agreement for a Temporary (Interim) Chief Executive Officer

Chair Yost noted that Director Sanchez would not be participating in Agenda Item 23 because it involves a contract with him.

For the record, the Clerk verbally stated that the proposed contract that the Board was considering taking final action on today calls for an effective date of April 6, 2020, with the contract running through December 31, 2020 and continuing thereafter on a month-to-month basis unless terminated per the terms of the contract, an annual salary of $409,245, a monthly car allowance of $550, the right to participate in all benefit plans and programs established for the benefit of CalOptima employees, employer payment of the employee's portion of his CalPERS retirement plan under the applicable formula, supplemental PARS contributions based on the same percentage applicable to all employees, term life insurance in an amount equal to two times the employee's annual salary, a paid time off (PTO) accrual rate of 33 days per year, plus two additional weeks of PTO provided to the employee upon the effective date of the employment agreement.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Approved Executive Employment Agreement for Richard Sanchez to serve as the Temporary (Interim) Chief Executive Officer of CalOptima. (Motion carried 9-0-0; Director Sanchez recused)***

24. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment

Ms. Gibb introduced the item. After discussion, the Board took the following action:

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Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Authorized selection of an executive search firm for chief executive officer (CEO) recruitment consistent with the Board-approved purchasing policy and directed staff to return with recommendations, requesting that the selected firm not charge a recruitment fee in the event that an internal candidate is selected. ~~authorized staff to enter into a contract with the selected firm~~ and 2) Authorized unbudgeted expenditures from existing reserves for recruitment services and related expenditures in the amount not to exceed $250,000 to fund the CEO recruitment contract. (Motion carried 9-0-0)*** Amended 4/2/2020

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors appointed Hai Hoang to serve as the Persons with Disabilities Representative of the Member Advisory Committee for the remainder of the term ending June 30, 2021. (Motion carried 9-0-0)***

As noted at the top of the agenda, Chair Yost reordered the agenda to hear Agenda Item 33. prior to hearing Agenda Item 26.

INFORMATION ITEM

33. Whole Child Model Financial Update

Ms. Huang provided an update on the Whole-Child Model Financials including additional details on the $31 million-dollar deficit and steps CalOptima management is taking to mitigate losses on this program.

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of: a.) Additional initiative(s) related to member access and engagement; and b.) New and/or modified policies and procedures, and contracts/contract amendments, as applicable. (Motion carried 9-0-0)***

27. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Authorized expenditure for CalOptima's participation in the following community events: a.) Up to $1,000 and staff participation at the Orange***

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County Women's Health Projects' 8th Annual Orange County Women's Health Summit on May 29, 2020 in on-line webinar format; 2.) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3.) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. as necessary for the events and expenditures. (Motion carried 9-0-0)

ADVISORY COMMITTEE UPDATES

28. Member Advisory Committee Update

Christine Tolbert, MAC Chair, provided a brief update, noting that the MACs report is in the Board packet. Ms. Tolbert also mentioned that the MAC continues to have interest in receiving in-person State/Federal legislative updates at the MAC meeting.

29. Provider Advisory Committee Update

John Nishimoto, O.D., PAC Chair, provided a brief update and noted that a joint MAC/PAC meeting would be held on April 9, 2020. He indicated that the PAC is also interested in receiving in-person State/Federal legislative updates at PAC meetings. In addition, Mr. Nishimoto wished Michael Schrader well and thanked him for his service.

30. OneCare Connect Member Advisory Committee Update

Chair Yost noted that Patty Mouton is unable to join today's meeting.

INFORMATION ITEMS

Chair Yost noted that staff has done a thorough job in preparing the remaining information items and asked fellow Board Members if they had any specific questions on any of the items. Hearing none, the following agenda items were accepted as presented.

32. Introduction to the FY 2020-21 CalOptima Budget: Part 1

Ms. Huang did note that CalOptima staff will be sending out additional information to assist the Board in preparing for Part 2 of the Budget Kick Off scheduled for the May meeting.

34. February 2020 Financial Summary
35. Compliance Report
37. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members thanked Mr. Schrader for his service to CalOptima and congratulated Mr. Sanchez on his appointment as Interim Chief Executive Officer.

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ADJOURNMENT
Hearing no further business, the meeting was adjourned at 5:40 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 7, 2020

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

April 16, 2020

A Special Meeting of the CalOptima Board of Directors was held on April 16, 2020 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 Paul Yost, M.D. called the meeting to order at 2:00 p.m. Interim Chief Executive Officer, Richard Sanchez led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair (2:03 p.m.); Ria Berger; Ron DiLuigi; Supervisor Andrew Do; Lee Penrose; Scott Schoeffel; Supervisor Michelle Steel (Out 2:50 – 3:08 p.m.); Bob Wilson (Non-Voting) (2:03 p.m.) (All members at teleconference locations except the Chair)

Members Absent: Alexander Nguyen, M.D.

Others Present: Michael Schrader, Chief Executive Officer (CEO); Richard Sanchez, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; David Ramirez, Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS

1. Isabel Becerra, Coalition of Orange County Community Health Centers – Oral re: Community Clinic testing for the Coronavirus.

INFORMATION ITEMS

1. COVID-19 Update

David Ramirez, M.D., Chief Medical Officer provided an update on CalOptima's response to the Coronavirus pandemic. Dr. Ramirez noted that guidance at the federal, state, and local levels is very dynamic and continues to be updated on an almost daily basis. Topics in the update included health care system changes, telehealth, homeless population, COVID-19 testing, communications to providers and members, CalOptima workforce status, federal and state updates, as well as an update on financial implications.

REPORTS

2. Consider Modifications to the CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative in Response to COVID-19

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

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Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Authorized modification of the existing Homeless Clinic Access Program (HCAP) Homeless Health Initiative to include: a.) Telehealth visits; b.) On-call services provided through the Clinical Field Team Pilot Program (CFTPP); and 2.) Authorized the expenditure of up to $1 million in provider incentives consistent with this proposed modification to the HCAP. (Motion carried 7-0-0; Director Schoeffel recused; Director Nguyen absent)***

3. Consider Authorizing Modifications to the Post-Acute Infection Prevention Quality Initiative During the Coronavirus Disease (COVID-19) Crisis

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO) to temporarily modify the Post-Acute Infection Prevention Quality Initiative (PIPQI) by: 1.) Suspending skin testing requirements during the Coronavirus (COVID-19) pandemic, and 2.) Allowing early disbursement of the first quarterly incentive payment (January – March 2020) and prepayment of the second quarterly payment (April – June 2020) due to added Personal Protective Equipment (PPE) and personnel costs in participating skilled nursing facilities. (Motion carried 8-0-0; Director Nguyen absent)***

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Ratified and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and 2.) Authorized 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. (Motion carried 7-0-0; Director Schoeffel recused; Director Nguyen absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

The Board welcomed Bob Wilson to the CalOptima Board of Directors as the HCA Representative and wished outgoing CEO Michael Schrader success in his future endeavors.

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ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:19 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 7, 2020

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MINUTES

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

February 27, 2020

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held on February 27, 2020 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:14 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Patty Mouton, Chair; Gio Corzo, Vice Chair; Josefina Diaz; Sandy; Keiko Gamez; Sara Lee; Mario Parada; Donald Stukes; Erin Ulibarri (non-voting)
Members Absent:	Sandra Finestone; Adam Crits, M.D. (non-voting), Jyothi Atluri (non-voting)
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., 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; Albert Cardenas, Director, Customer Service (Medicare); Andrew Tse, Manager, OneCare Connect Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant, Customer Service.

MINUTES

Approve Minutes of the October 10, 2019 Special Meeting of the CalOptima Board of Directors' 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).

Action: ***On motion of Member Josefina Diaz, seconded and carried, the Committee approved the minutes of the October 10, 2019 meeting. (Motion carried 7-0-0; Member Finestone absent)***

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Approve the Minutes of the October 24, 2019 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Sara Lee, seconded and carried, the Committee approved the minutes of the October 24, 2019 meeting. (Motion carried 7-0-0; Member Finestone absent)***

Consider Recommendation to Revise OneCare Connect Member Advisory Committee Chair and Vice Chair Term Lengths

The Joint Advisory Recruitment Ad Hoc Committee recommended that the Chair and Vice Chair term lengths be changed from a one-year term to a two-year term to be aligned with both the Provider Advisory Committee (PAC) and the Member Advisory Committee (MAC).

Action: ***On motion of Member Keiko Gamez, seconded and carried, the Committee approved the recommendation to revise the OCC MAC Chair and Vice Chair Term Lengths (Motion carried 7-0-0; Member Finestone absent)***

PUBLIC COMMENT

There were no requests for public comment

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, provided a verbal update on how CalOptima's Program of All-Inclusive Care to the Elderly (PACE) has been recognized for increasing access to services by the National PACE Association. Mr. Schrader also noted that CalOptima's PACE Program also achieved "Supernova" and "Shooting Stars" distinctions.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided a verbal update on the Qualified Medicare Beneficiary (QMB) Program outreach to the members. Ms. Khamseh noted that CalOptima has received approximately 450 forms out of the 650 forms that were mailed out to members. Ms. Khamseh also discussed CalOptima's new Behavioral Health internal transition and its benefits for the OneCare and OneCare Connect members which launched on January 1, 2020.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided a verbal update on CalOptima's collaboration with the Orange County Health Care Agency regarding the Coronavirus (COVID-19). He noted that CalOptima had also formed an internal COVID-19 response team.

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INFORMATION ITEMS

OCC MAC Member Updates

Chair Mouton reminded the Committee that recruitment opens for the following seats beginning March 1, through March 31st. She noted that the following seats have terms expiring on June 30, 2020, Community Based Adult Services (CBAS) Provider, Long Term Services and Supports, Member Advocate, Member-Family Member and Seniors. Ms. Mouton asked members of the Committee to form a Nominations Ad Hoc Committee to review and score the applications that are received for the seats that were noted. The Nominations ad hoc committee will consist of Mario Parada, Sara Lee, and Josefina Diaz. Ms. Mouton also formed a Goals and Objectives ad hoc to review the CalOptima Strategic Plan for 2020-2022 and formulate Goals and Objectives. Chair Patty Mouton, Josefina Diaz and Keiko Gamez agreed to be on this ad hoc committee.

Health Homes Update

Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on the Health Homes Program (HHP), which went live on January 1, 2020. Ms. Hitzeman mentioned that approximately 3,000 CalOptima members are eligible for phase one of this program, including the homeless members who meet the criteria. She noted that outreach via robo-call began in January and approximately 1247 individuals were reached, with 34 members opting into the program.

Intergovernmental Transfer (IGT) 9 Update

Candice Gomez, Executive Director, Program Implementation, provided a presentation on the Intergovernmental Transfer (IGT) 9 funds that CalOptima is expecting. Ms. Gomez noted that CalOptima will receive approximately $45 million which will be available to be used for Medi-Cal services. Beginning with IGT 8, the state views IGT funding as part of the capitation CalOptima receives in exchange for providing medically necessary, covered services for Medi-Cal beneficiaries. She also mentioned that there are four focus areas that have been identified for possible use of these funds, including member access and engagement, quality performance programs, data exchange and support and other identified priority areas.

Medi-Cal Healthier California for All Presentation

Candice Gomez, Executive Director, Program Implementation, also presented on the Medi-Cal Healthier California for All and noted that the Department of Health Care Services (DHCS) had decided to return to the original name of California Advancing and Innovating Medi-Cal (CalAIM). Ms. Gomez provided an overview of the goals for this program as well as the DHCS timeline for this new program. CalAIM will be implemented statewide in stages and concluding with full integration by January 1, 2026. She also noted that CalOptima is required to submit a transition plan by July 2020 that addresses how the Whole-Person Care and HHP will enhance care management and in lieu of services, effective January 2021.

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ADJOURNMENT

Vice Chair Corzo announced that the next regular meeting would be held on Thursday, April 23, 2020 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 5:05 p.m.

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

Approved: April 23, 2020

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Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Approval of New CalOptima Policy AA.1500: Medical Respite Program and Authorization of Related Amendment of the County Coordination and Provision of the Public Health Care Services Contract

Contact

Tracy Hitzeman, Executive Director, Medical Management, (714) 246-8400

Recommended Actions

1. Approve new CalOptima Policy AA.1500: Medical Respite Program; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the CalOptima-County of Orange Coordination and Provision of Public Health Care Services Contract to reflect requirements associated with the Medical Respite Program pursuant to new CalOptima Policy AA.1500

Background/Discussion

Whole Person Care (WPC) is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home. WPC, including recuperative care, is administer by the Orange County Health Care Agency (OCHCA).

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA staff that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy, do not qualify for transition to inpatient stay or nursing facility care, and will benefit from medical respite care beyond the 90 days of recuperative care. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. To ensure care coordination and continuity of care, it is anticipated that services will be provided by WPC recuperative care providers.

On April 4, 2019, the CalOptima Board of Directors (Board) established a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the OCHCA WPC pilot. The Board authorized reimbursement of the full medical respite stay up to $120 per day for all bed days beyond the days available through the WPC Pilot Recuperative Care Program, not to exceed a cumulative grand total of $250,000 and authorized staff to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for

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medically justified medical respite services. The Board further directed staff to return to the Board for approval of applicable implementing policies.

The Medical Respite Program is intended to provide support to CalOptima members experiencing homelessness who have received WPC recuperative care for the ninety (90) day maximum authorized under the WPC program, do not meet criteria for inpatient stay or nursing facility placement, who lack a stable living situation, and whose medical condition(s) necessitate continued services to support the provision of medical treatment and care coordination. CalOptima and County WPC staff collaborated in development of the proposed Medical Respite Program, leveraging the existing WPC infrastructure.

As reflected in new policy AA.1500: Medical Respite Program, CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis by County WPC staff and County nurses; members who are certified for hospice care or needing intravenous (IV) chemotherapy may be preapproved by County staff for up to 90 days without prior approval. The policy further requires regular reviews and updates by county public health nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical stability and steps to move to a skilled nursing facility (SNF), if appropriate. Additionally, the policy requires prior approval for extensions after the first 90 day under the CalOptima Medical Respite Program. The policy also addresses processes for CalOptima's reimbursement for the Medical Respite Stay and monitoring utilization and member outcomes. Staff seeks authority to amend the County Coordination and Provision of Public Health Care Services Contract consistent with the policy.

CalOptima and County staff continue to develop guidelines for CalOptima Members who may benefit from the Medical Respite Program but are not certified for hospice care or needing IV chemotherapy. These Members will be referred to CalOptima for eligibility determination prior to receiving Medical Respite Program services. Staff will return to the Board for approval to update the policy and amend the contract, as appropriate, when such guidelines are developed for the Medical Respite Program.

Fiscal Impact

The recommended action to approve CalOptima Policy AA.1500: Medical Respite Program and authorize amendment of the related County Coordination and Provision of the Public Health Care Services Contract has no fiscal impact to CalOptima's operating budget. Pursuant to the Board action taken on April 4, 2019, a reallocation of Intergovernmental Transfer (IGT) 6/7 funds in the amount of $250,000 will fund the Medical Respite Program. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommend approval of this policy and amendment of this County contract to support CalOptima Members who do not meet the medical necessity criteria for continued inpatient care or level of care criteria for skilled nursing but lack a stable living situation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. New Policy AA.1500: Medical Respite Program
3. CalOptima Board Action dated April 4, 2019, Consider Authorizing Post WPC Medical Respite Care

/s/ Richard Sanchez — *04/29/2020*

Authorized Signature — **Date**

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Attachment 1 to May 7, 2020 Board of Directors Meeting– Agenda Item 3

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Orange County Health Care Agency	405 W 5th St.	Santa Ana	CA	92701

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Policy:	AA.1500
Title:	**Medical Respite Program**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy outlines CalOptima Medical Respite Program guidelines and the process to identify, assess, and coordinate care for eligible Members.

II. POLICY

A. The CalOptima Medical Respite Program is intended to provide support to Members who are experiencing homelessness, have received Whole Person Care (WPC) Recuperative Care for the ninety (90)-calendar day maximum authorized under the WPC program and meet specific criteria in Section III.A. of this Policy.

B. If at any time, Orange County Health Care Agency (OCHCA) WPC and/or nursing staff considers a Member's condition to deteriorate such that care under the CalOptima Medical Respite Program is no longer appropriate, OCHCA WPC and/or nursing staff shall consult with Member's primary care provider for consideration of the most appropriate level of care option including nursing facility level of care and, if applicable, coordinate with CalOptima or the Member's assigned Health Network to conduct further evaluation, as needed.

C. CalOptima shall contract with the OCHCA to administer the CalOptima Medical Respite Program to Members.

1. OCHCA WPC staff and OCHCA nursing staff shall evaluate a CalOptima Member on a case-by-case basis following the CalOptima Medical Respite Program eligibility criteria and procedures as described in Section III. of this Policy.

D. CalOptima shall reimburse the OCHCA for CalOptima Members meeting the eligibility criteria and procedure and participating in the CalOptima Medical Respite Program.

E. CalOptima shall provide oversight of OCHCA's determination process in accordance with Section III.G. of this Policy.

F. The CalOptima Medical Respite Program shall be subject to authorized Inter-Governmental Transfer (IGT) Funds allocated and remaining for the program.

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III. PROCEDURE

A. CalOptima Members receiving WPC Recuperative Care that are nearing the ninety (90)-calendar day maximum authorized under the WPC shall be evaluated by the OCHCA for eligibility for the CalOptima Medical Respite Program as follows:

1. The Member is expected to exhaust the WPC Recuperative Care ninety (90)-calendar days permitted under WPC;

2. The Member meets the criteria for discharge to, but does not have a home or other stable living situation at which to receive access to medical care, case management, and other supportive services;

3. The Member requires a safe and clean environment to access medical care, case management, and other supportive services in order achieve and maintain medical stability.

4. The anticipated need for Medical Respite Care for the Member is limited to ninety (90) calendar days, unless authorized in accordance with Section III.C. of this Policy; and,

5. Member is certified for hospice care, as set forth in Section III.A.5.a of this Policy or is receiving or scheduled to receive intravenous (IV) chemotherapy (including adequate time to achieve post-treatment for the Member's recovery from the effects of chemotherapy) as set forth in III.A.5.b of this Policy.

   a. Member has elected hospice care, does not meet criteria for nursing facility placement, and would otherwise be unable to access hospice care due to the lack of a stable living situation.

   b. For purposes of Section III.A.5 of this Policy, recovery from the effects of chemotherapy means:

      i. The Member is able to tolerate adequate dietary intake;

      ii. No more than twenty-one (21) days have elapsed after the Member received the last IV dose of chemotherapy; and

      iii. The Member is independent with mobility, with or without assistive devices, including wheelchairs.

B. Notice of Member Eligibility and Transition to CalOptima Medical Respite Program

1. If the Member remains in WPC Recuperative Care through the end of the WPC permitted ninety (90)-calendar day period, and continues to meet the criteria as determined in Section III.A. of this Policy, the OCHCA shall notify CalOptima of the Member's eligibility and transition to the CalOptima Medical Respite Program and include the expected length of stay not to exceed ninety (90) calendar days.

C. Renewal of CalOptima Member Medical Respite Care

1. In the event that a CalOptima Member continues to meet CalOptima Medical Respite Program criteria towards the end of approved Medical Respite Care stay, the OCHCA shall inform CalOptima.

a. CalOptima Medical Respite Program renewal requests may be submitted without limit so long as the CalOptima Member continues to meet CalOptima Medical Respite Program criteria and the CalOptima Medical Respite Program is available. CalOptima's prior approval is required for renewal of the Member's Medical Respite Care.

2. Ten (10) calendar days prior to the end of the allowed Medical Respite Care stay, the OCHCA shall provide documentation to CalOptima, via secure email:

a. The Member has continued need for Medical Respite Care beyond the approved period; and

b. A current medical report prepared by the hospice provider within thirty (30) calendar days of CalOptima's receipt of the report, which indicates continued hospice participation; or,

c. A current report prepared by the Member's treating oncologist within thirty (30) calendar days of CalOptima's receipt of the report, which includes the date of the last dose of IV chemotherapy (whether or not administered), as applicable.

3. Within five (5) business days of receipt of the documentation set forth in Section III.C.2. of this Policy, CalOptima shall notify OCHCA in writing of the decision to approve, deny, or modify the renewal request for CalOptima Medical Respite Program.

D. During the Member's stay in CalOptima Medical Respite Program, the OCHCA WPC staff and providers shall make all reasonable efforts to assist the Member in obtaining appropriate housing following the stay.

E. During the Member's stay in CalOptima Medical Respite Program, should the Member's condition deteriorate such that the Medical Respite Care location is unable to adequately and safely support the Member, OCHCA staff shall contact the Member's primary care provider or 911 in the case of emergency, as appropriate. Following an evaluation by a physician, should a nursing facility level of care be medically appropriate, OCHCA staff should notify CalOptima or the Member's assigned Health Network to assist in coordination for the nursing facility admission.

F. CalOptima Medical Respite Program Payment

1. For payment processing, OCHCA shall submit an invoice to CalOptima, in accordance with the Contract, and include:

a. Member Name;

b. Member CalOptima Identification Number (CIN);

c. Member's dates of stay and cumulative total days of CalOptima Medical Respite Program stay;

d. If, applicable, CalOptima Medical Respite Program dates of stay/lengths of stay previously billed; and,

e. Other requirements as specified by CalOptima.

2. CalOptima shall issue all applicable payment(s) directly to the OCHCA, in accordance with the Contract.

3. CalOptima shall not be responsible for reimbursement of:

a. Services provided to an individual who was not a CalOptima Member at the time of service;

b. Services provided to an individual (CalOptima Member or not) who did not meet the CalOptima Medical Respite Program criteria at the time of service;

c. Billed amounts exceeding the permitted Medical Respite Care days as described herein; and/or;

d. Reimbursement request(s) exceeding the maximum agreed amount, or total IGT Funds approved by the CalOptima Board of Directors for CalOptima Medical Respite Program.

4. The OCHCA shall be responsible for tracking a Members' cumulative length of stay and the remaining authorized IGT Funds for the CalOptima Medical Respite Program.

G. Monitoring of OCHCA Determination Process

1. CalOptima shall monitor utilization and outcomes.

a. On a quarterly basis, the OCHCA shall submit a report encompassing the period from inception to the end of last calendar quarter. The reports related to CalOptima Medical Respite Program shall include the following:

i. Number of unique Members served;

ii. Amounts paid, accrued, and unpaid;

iii. Balance remaining;

iv. Amounts expected to be incurred based on current census;

v. For discharges, the locations to which the Member was discharged; and

vi. The number of Members currently in CalOptima Medical Respite Program expected to be discharged at the end of the approved stay or expected to require extension.

b. CalOptima and OCHCA shall meet on a quarterly basis to review and discuss:

i. The results reflected in the reports related to CalOptima Medical Respite Program Report provided in accordance with Section III.G.1.a.

ii. Any challenges and barriers;

iii. Best practices; and,

iv. Case studies, if applicable.

2. OCHCA shall submit a file to CalOptima for review for each Member who has transitioned from WPC Recuperative Care to CalOptima Medical Respite Program pursuant to Section III.A. of this Policy:

a. The file submission for each Member shall include:

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i. Diagnosis;

ii. Documentation supporting that the Member meets the criteria in Sections III.A.1-5 of this Policy; and

iii. Treatment plan.

b. Such file shall be submitted within fifteen (15) calendar days following transition to the CalOptima Medical Respite Program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Amendment 5 to the Coordination and Provision of Public Health Services Contract between the Orange County Health Authority ("CalOptima") and the County of Orange, through its division the Orange County Health Care Agency

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	AA.1500	Medical Respite Program	Medi-Cal

IX. GLOSSARY

Term	Definition
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
Inter-Governmental Transfer (IGT) Funds	Transfers of public funds between or within levels of government. The transfer of funds may take place from one level of government to another (e.g., county to state) or within the same level of government (e.g., from a state university hospital to the state Medicaid agency). States can use county or state funds as the match for federal funds.
Medical Respite Care	Care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital or nursing facility. Short-term residential care providing a safe environment and coordinating continued medical care and other supportive services, including post-acute care and clinical oversight.
CalOptima Medical Respite Program	Program for CalOptima Members who have met defined clinical criteria for the program and who have exhausted the available Recuperative Care days under the OCHCA WPC program.
Member	An enrollee-beneficiary of a CalOptima program.
Orange County Health Care Agency (OCHCA)	Orange County Health Care Agency is a regional provider, charged with protecting and promoting individual, family and community health through coordination of public and private sector resources.
Recuperative Care	Post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury but do not meet the medical necessity criteria for continued inpatient care. While typically referred from an acute setting as part of a discharge plan, referrals may be made from other settings such as skilled nursing or from the street.
Skilled Nursing Facility (SNF)	An institution or part of an institution that meets criteria for accreditation established by the sections of the Social Security Act that determine the basis for Medicaid and Medicare reimbursement for skilled nursing care.
Whole Person Care (WPC)	Pilot program designed to enhance coordination of health and social services for the County of Orange homeless population and administered by the Orange County Health Care Agency.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

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pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact

The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

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funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

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Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

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

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

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- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

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These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

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IGT Progress Report and Proposal

Board of Directors Meeting

October 1, 2015

Lindsey Angelats

Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

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Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

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- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

Contact
David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to modify the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B); and
2. MA.6104 Opioid Medication Utilization Management

Background/Discussion
CalOptima regularly reviews its 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 the policies that require modification:

1. **Policy GG.1804*: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)*** describes the process for authorizing a Member's admission to, continued stay in, or discharge from a qualified, Out-of-Network, Subacute, or Long-Term Care Nursing Facility Level A (NF-A) and Level B (NF-B). CalOptima staff revised this policy pursuant to the CalOptima annual review process. More detail has been included describing timeframes for authorization decisions and notification of those decisions and clarifying that an authorization request shall be considered denied if the decision is not rendered within the required timeframe. Information has also been added about the process for extending the decision timeframe when incomplete information has been submitted and to improve the clarity of the policy.

2. **Policy MA.6104*: Opioid Medication Utilization Management*** outlines the process by which CalOptima identifies and minimizes potential opioid medication overutilization among OneCare and OneCare Connect Members. CalOptima staff has updated policy language consistent with the most recent guidance from the Centers for Medicare & Medicaid Services (CMS). Information has also been added regarding new Opioid Point-of-Sale edits and the Drug Management Program that became effective on January 1, 2019. Current reporting requirements and processes have also been updated, and PACE has been included as an applicable line of business.

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Fiscal Impact

The recommended action to revise existing CalOptima medical policies and procedures is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

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. CalOptima Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B). (Redlined and Clean versions)
2. CalOptima Policy MA.6104: Opioid Medication Utilization Management (Redlined and Clean versions)

/s/ Richard Sanchez — *04/29/2020*

Authorized Signature — **Date**

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Policy ~~#~~:	GG.1804
Title:	**Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)**
Department:	Medical ~~Affairs~~Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	06/01/98
Revised Date:	~~08/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria for authorizing a Member's admission to, continued stay in, or discharge from a qualified, Out-of-Network Subacute, ~~Skilled~~Long-Term Care Nursing Facility Level A (NF-A) and Level B (NF-B).

II. POLICY

A. CalOptima shall authorize room and board services for a Member's admission to, continued stay in, or discharge from, an Out-of-Network Qualified Subacute, ~~Skilled~~Long-Term Care NF-A and NF-B Facility under any of the following conditions:

1. The placement is court ordered, or under the direction of a court appointed conservator; or

2. The placement is intended for short-term rehabilitation, or stabilization, until such time that travel will not jeopardize the Member's health.

B. If nursing facility beds are not available within CalOptima's network, CalOptima shall enter into a Letter of Agreement (LOA) or contract with an Out-of- Network Qualified Nursing Facility, in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

C. If a Member resides in an Out-of-Network ~~Skilled~~Long-Term Care Nursing Facility prior to enrollment, the Member shall remain in the Facility in accordance with CalOptima Policies CMC.6021a: Continuity of Care for New Members, and GG.1325: Continuity of Care for ~~Medi-Cal Beneficiaries Who Transition~~Members Transitioning into CalOptima Services.

D. The CalOptima Long Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a ~~-~~Subacute –Adult, Subacute-Pediatric, NF-A and NF-B Facilities pursuant to Title 22, California Code of Regulations, §§51334, 51335, 51511 and the Department of Health Care Services (DHCS) standard clinical criteria for level of care.

E. If CalOptima is unable to render a decision within the required timeframe, it shall be considered a denial. CalOptima will notify the subacute, NF-A or NF-B facility in accordance with CalOptima Policies GG. 1814: Appeals Process for Long Term Care Facility and GG.1510: Appeal Process.

~~Terms in **bold** are included in the Glossary.~~

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~~E.~~F. CalOptima shall limit authorization to a Subacute-Adult, Subacute~~—~~Pediatric,~~-~~ NF-A and NF-B Facilities, that are licensed and certified by the California Department of Public Health (CDPH) and approved by the Department of Health Care Services (DHCS), in accordance with State and Federal regulations, and contracted with CalOptima in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

III. PROCEDURE

A. A nursing facility shall notify the CalOptima LTSS Department by facsimile, mail, or telephone, of a Member's admission to a Subacute-Adult, Subacute-Pediatric, NF-A or NF-B facilities in accordance with CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B) and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric.

B. The NF-A and NF-B facilities shall submit a reauthorization request prior to the expiration of the active Long~~-~~Term Care (LTC) Authorization ~~Request Form (ARF).~~. The facility may submit the reauthorization request up to sixty (60) calendar days prior to expiration of the active ~~LTC ARF.~~Authorization. The reauthorization requests shall include a completed LTC ARF (Sections I, III, and IV) signed by the Physician, and medical records sufficient ~~documentation~~ to determine the level of care and justify continued stay.

C. A Subacute Facility shall submit a reauthorization request prior to the expiration of the active LTC ~~ARF.~~Authorization. The facility may submit the reauthorization request up to thirty (30) calendar days prior to expiration of the active LTC ~~ARF.~~Authorization. The authorization requests shall include a ~~completed LTC ARF (~~copy of a signed MD Order for admission to the nursing facility or an ARF with MD signature and Section I, III and IV~~), signed by~~ completed on the ~~Physician, a~~ARF. A signed 6200-A/6200 form, and medical records sufficient ~~documentation~~ to determine the level of care and justify a continued stay must be included with the completed ARF.

~~III.I. PROCEDURE~~

D. CalOptima shall utilize the DHCS standard clinical criteria in the LTC ARF ~~adjudication~~evaluation process as stated in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long Term Care Services.

E. If the LTC ARF and required attachments are incomplete, the ~~CalOptima LTSS Department shall defer and return the incomplete LTC ARF and attachments to the~~ Subacute, NF-A or NF-B Facility will be requested to resubmit ARF with additional requested information~~. The facility shall resubmit the LTC ARF~~ within ~~thirty (30~~fourteen (14) calendar days. If the nursing facility does not provide the requested documents after the ~~submission of the~~ initial ~~ARF, or the ARF~~fourteen (14) calendar days of the authorization request, the request shall be subject to denial. ~~Deferrals may be extended in thirty (30) calendar day increments~~An extension of fourteen (14) calendar days may be granted if the Member or Member's Physician requests the extension; or the CalOptima Nurse Case Manager justifies a need for additional information and if the extension is in the Member's best interest. The extension period is to allow the Nursing Facility time to collect required documentation (~~i.e.~~, ~~PASRR Level II Screening Documents) by submitting~~ e.g., specialist consults, additional tests required, etc.).The CalOptima Nurse Case Manager will document the need for extension and how it is in the member's best interest in the member's electronic medical record.

~~E.~~F. The CalOptima LTSS Department shall issue a deferral ~~extension request form.~~notice (Delay letter) if CalOptima LTSS Department extends the timeframe an additional fourteen (14)

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calendar days, up to a maximum of twenty-eight (28) calendar days total from the day of initial notification.

G. ~~C~~Upon receipt of all information reasonably necessary and requested, CalOptima LTSS Department shall approve, modify, or deny the request for authorization within five (5) business days.

H. If the CalOptima LTSS Department is unable to approve the LTC ARF due to insufficient documentation of Medical Necessity, the CalOptima LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Medical Director, or physician Designee, for review and determination.

1. If CalOptima's Medical Director, or physician Designee, approves the LTC ARF, the CalOptima LTSS Department shall send a copy of the approved LTC ARF to the Facility.

2. If CalOptima's Medical Director, or physician Designee, denies the LTC ARF, the CalOptima LTSS Department shall notify the Subacute, NF-A or NF-B Facility~~,~~ within one business day, and the Member or Member's Authorized Representative~~, and the attending Physician,~~ within two business days in accordance with CalOptima Policies GG.1814: Appeals Process for Long Term Care Facility ~~Daily Rate Denial, Modification or Recommendation~~ and GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

I. Upon notification by the Nursing Facility of the Member's discharge, the CalOptima LTSS Department shall close the active LTC ARF effective the day of discharge:

1. The Nursing Facility shall notify CalOptima within ~~three (3~~one (1) business days of a Member's discharge by sending the Nursing Facility ~~a~~ "Discharge Disposition Form" ~~and~~to the ~~Medi-Cal LTC Facility Discharge Notification Form (MC171).~~LTSS department.

2. The nursing facility shall send the Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agencies.

J. CalOptima's LTSS Department shall notify the appropriate departments, and Health Network, for further Care Coordination.

IV. ATTACHMENT(S)

A. CalOptima Long Term Care Authorization Request Form (ARF)
B. CalOptima Nursing Facility Discharge Disposition Form
C. Medi-Cal LTC Facility Discharge Notification Form (MC171)
D. Information for Authorization/Reauthorization of Subacute Care Services-Adult Subacute Program (DHCS 6200-A)
E. Information for Authorization/Reauthorization of Subacute Care Services-Pediatric Subacute Program (DHCS 6200).

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~A.~~C. CalOptima Policy CMC.6021a~~-~~: Continuity of Care for New Members

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~~B.~~D. CalOptima Policy EE.1135: Long Term Care Facility Contracting
~~C.~~E. CalOptima Policy GG.1325: Continuity of Care for ~~Medi-Cal Beneficiaries Who Transition~~Members Transitioning into CalOptima Services
~~D.~~F. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
~~E.~~G. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
~~F.~~H. CalOptima Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in and Discharge from a Subacute Facility-Adult/Pediatric.
I. CalOptima Policy GG.1814: Appeals Process for Long Term Care Facility ~~Daily Rate Denial, Modification or Recommendation~~
~~G.A.~~
~~H.A. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~I.~~J. CalOptima Utilization Management Program
~~J.~~K.~~CalOptima Contract with the~~ Department of Health Care Services All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "YOUR RIGHTS" Attachments
~~K.~~L. CMS Nursing Home Quality Initiative MDS for Nursing Homes and Swing Bed Providers
~~L.~~M. Manual of Criteria for Medi-Cal Authorizations, Medi-Cal Policy Division
~~M.~~N. Medi-Cal Provider Manual, Section: Admissions and Discharges
~~N.~~O. Title 22, California Code of Regulations (CCR.), §§51006, 51120, 51121, 51124, 51212, 51134, 51335, and 51511
~~O.~~P. Welfare and Institutions Code, §14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/16	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	06/01/1998	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Skilled Nursing Facilities (SNF)	Medi-Cal
Revised	07/15/1998	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Skilled Nursing Facilities	Medi-Cal
Revised	02/01/2007	GG.1804	Admission to, Continued Stay in, and Discharge From Out-of State Skilled Nursing Facilities	Medi-Cal

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~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Revised	02/01/2016	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	08/01/2016	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	08/01/2017	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised		GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: ~~Has the meaning given such term in section 164.502(g) of Title 45, 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. OneCare Connect: ~~Any~~An individual ~~authorized~~ either appointed by a Member~~,~~ or authorized under ~~state~~State or other applicable law~~,~~ to act on ~~his or her~~ behalf ~~in obtaining an Organization Determination~~of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the ~~Appeal~~Appeals process. ~~An Authorized Representative is subject to the rules described in Title 20~~Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part ~~404~~423, Subpart ~~R, unless otherwise stated in~~ M, the ~~Medicare Managed Care Manual (Use form CMS-1696 for Claims Adjudication~~representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or ~~Claim~~in dealing with any of the levels of the Appeals process~~).~~, subject to the rules described in Part 422, Subpart M.
Long-Term Care Nursing Facility	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.
Member	An enrollee-beneficiary of a CalOptima Program.
Nursing Facility Level A (NF-A)	Nursing Facility Level A (NF-A) is known as the Intermediate Care level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Nursing Facility Level B (NF-B) is known as the ~~Skilled~~Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Out-of- Network	For purposes of this policy, refers to a Non-Contracted Long~~-~~-Term Care Facility Provider
Qualified Nursing Facility	For purposes of this policy, refers to Subacute, Nursing Facility Level A (NF-A~~),~~), Nursing Facility Level B (NF-B). The facility is licensed by the State, meets acceptable quality standards and accepts Medicaid rates for Medicaid services and Medicare rates for Medicare services.
~~Skilled Nursing Facility~~	~~Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section~~

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Term	Definition
	~~51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.~~
Subacute Facility	For purposes of this policy, refers to Subacute Adult and Pediatric facilities.
Subacute ~~–~~Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.8 as an identifiable unit of a SNF accommodating beds including continuous room, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Tile 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for ~~the purpose of providing subacute care services for Members under twenty one (21) years of age.~~such purpose.

CalOptima
A Public Agency
Better. Together.
P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Denied ☐ Approved as Modified ☐ Deferred
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:
- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:
- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes
- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

Admissions and Discharges

This section describes admission and discharge procedures for Long Term Care (LTC) facilities.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

Medi-Cal Long Term Care Facility Admission and Discharge Form (MC 171)

NF-As and NF-Bs are required to complete the *Medi-Cal Long Term Care Facility Admission and Discharge Notification* (MC 171) form on admission or discharge of a patient. (See *Figures 1* thru *3* on a following page in this section.)

Admission Procedures

On admission to an LTC facility, a Medi-Cal recipient or the recipient's representative must complete the *Medi-Cal Long Term Care Facility Admission and Discharge Notification* (MC 171) form, Parts I and II.

The MC 171 must have the original signature of the recipient. If the recipient's signature cannot be obtained (for example, in the case of a comatose recipient), the facility representative must indicate the reason the recipient's signature cannot be obtained.

Supplemental Security Income Recipients

When a Supplemental Security Income (SSI) recipient enters a Nursing Facility (NF), providers must notify a Social Security Administration (SSA) field office of the recipient's name, Social Security Number (SSN) and date of entry. SSI recipients are required to report their status to the provider when entering an NF.

Form Submission to Government Agencies

The LTC facility must retain a copy of the MC 171 for its files and send either the original or a copy to the proper government agencies depending on whether:

- A patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP). The original MC 171 should be sent to the local Social Security Office. The aid code for these recipients is 10, 20 or 60. A copy of the MC 171 should be forwarded to the local county welfare department.
- A patient receives aid under any program other than SSI/SSP. The original MC 171 should be sent to the local county welfare department. The aid code for these recipients will be other than 10, 20 or 60.

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Form Submission Not Required by DHCS, Medi-Cal Eligibility Division	The LTC facility is not required to submit a copy of the MC 171 form to the Department of Health Care Services (DHCS), Medi-Cal Eligibility Division. The Medi-Cal consultant will use the recipient's initial *Treatment Authorization Request* (TAR) as notification of the patient's admission.
Routine or Standing Orders – Hospitals and Skilled Nursing Facilities	Services billed to Medi-Cal that are the result of routine or standing orders for admission to a hospital or NF-B are not payable when applied indiscriminately to all patients. All patient orders, including standing orders for particular types of cases, must be specific to the patient and must represent necessary medical care for the diagnosis or treatment of a particular condition Claims for routine orders will be subject to audit for medical necessity and will be denied if not justified by the facts relating to the case or if in excess of current patient needs The use of routine or standing orders is discouraged by the American College of Surgeons, the California Medical Association, the California Association of Hospitals and Health Systems, the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association.
Discharge Procedures	When a patient receiving NF-A or NF-B expires or is discharged from an LTC facility, the facility must complete Part III of the MC 171 and submit the original to the county welfare department. Send a copy of the MC 171 to the TAR Processing Center only when submitting a TAR for dates of service prior to discharge (with the exception of bedhold TARs).
Discharge/Death on Day of Admission	If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable.

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Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A)

The *Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients* (MC 171A) form is an information sheet for facilities to use to advise SSI/SSP and Medi-Cal-only recipients of the need to complete the MC 171 (see *Figure 4* on a following page in this section). The form also explains a recipient's Share of Cost and the need to inform SSA and county welfare departments of a change in status.

Ordering Forms

Refer to the *Forms Reorder Request: Long Term Care* section in this manual for ordering information.

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

MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

(Instructions and distribution on reverse)

I. COMPLETE THIS PORTION FOR ALL ACTIONS

Patient's name (last) (first) (MI)

Name of facility

Social security number

Address (number and street)

Note: Level of care is SNF/ICF unless checked here as board and care ☐

City State ZIP code

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

Medi-Cal ID number (taken from the Medi-Cal card)

Admission date (month/day/year)

A. Do you have Medicare Part A, Hospital Coverage?
☐ Yes ☐ No

B. Expected length of stay:
☐ At least one full month after the month of admission
☐ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.
☐ Yes, beginning with month of _____, 20
☐ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):
☐ Supplemental Security Gold Checks
☐ Social Security Green Checks
☐ Other Income (i.e., railroad, military retirement, etc.)
☐ None

E. Admission from:
☐ Home ☐ Board and Care
☐ Household of another
☐ Acute Hospital— Home, B&C, other household immediately prior to acute
☐ Acute Hospital— SNF/ICF immediately prior to acute
☐ Acute Hospital extended stay— over 30 days
☐ Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital's address.)

Address (number and street)

City State ZIP code

G. Signature of recipient or representative payee or family member/other:

Signature of recipient

Signature of Representative Payee

Phone number

If recipient's signature cannot be obtained, please indicate reason in this space.

Signature of family member/other (indicate your relationship to the recipient.)

Phone number

III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:
☐ Discharged to Acute Hospital
☐ Discharged to another SNF/ICF
☐ Discharged to residence/home of another
☐ Discharged to Board and Care
☐ Discharged to other
☐ Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

Facility representative signature

Date

MC 171 (6/02)

Figure 1. Long Term Care Facility Admission and Discharge Notification (MC 171) Form.

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I. General Instructions

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local social security office for recipients with aid codes 10, 20, and 60. Send to the county welfare department (see attached list) for all other aid codes.

Copy 1: Attach to the Treatment Authorization Request (TAR) and send to the Department of Health Services, Medi-Cal field office in your area. It will be forwarded by the Medi-Cal field office to the county welfare department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use copy two of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal field office.

Copy 1: Send to the county welfare department (see attached list).

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in item II.C. of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a "YES" response would be indicated for item II.C. if Medi-Cal is expected to pay over $450 of the $900 charge for February.

MC 171 (6/02)

Figure 2. Long Term Care Facility Admission and Discharge Notification (MC 171) Form (Back).

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COUNTY/COORDINATOR	TELEPHONE NUMBER
01 Alameda County Social Services Agency P.O. Box 12941 Oakland, CA 94604	
Liz Blankenship	(510) 777-2343 FAX (510) 777-2310
02 Alpine County Department of Social Services 75 A Diamond Valley Road Markleeville, CA 96120	
Cami Chavez, Coordinator	(530) 694-2235 FAX (530) 694-2252
03 Amador County Department of Social Services 1003 Broadway Jackson, CA 95642	
Pattie Edmunds	(209) 223-6642 FAX (209) 223-6579
04 Butte County Department of Employment and Social Services P.O. Box 1649 Oroville, CA 95965-1649	
Carol Kuopus, Coordinator	(530) 538-3713 FAX (530) 538-4328
05 Calaveras County Social Welfare Department 891 Mountain Ranch Road San Andreas, CA 95249-9709	
Connie McLain	(209) 754-6447 FAX (209) 754-6724
06 Colusa County Department of Social Welfare P.O. Box 370 Colusa, CA 95932	
Sharon Carvalho	(530) 458-0275
07 Contra Costa County Employment and Human Services 40 Douglas Drive Martinez, CA 94553	
Daniel Chan	(925) 313-1619 FAX (925) 313-1710
08 Del Norte County Department of Social Services 880 Northcrest Drive Crescent City, CA 95531-3485	
Mary Yingst, Coordinator	(707) 464-3191 FAX (707) 465-1783
09 El Dorado County Department of Social Services 3057 Briw Road Placerville, CA 95667	
Lori Ogden	(530) 642-7323 FAX (530) 295-2724
10 Fresno County Department of Employment and Temporary Assistance 4944 E. Clinton Way, Suite 112 Fresno, CA 93750-0001	
Nancy Gillitzer	(559) 253-9271 FAX (559) 253-9250
11 Glenn County Human Resources Agency P.O. Box 611 420 East Laurel Street Willows CA 95988-0611	
Lily Montz, Coordinator	(530) 934-6514 ext. 139 FAX (530) 934-6521
12 Humboldt County Department of Health and Human Services 929 Koster Street Eureka, CA 95501	
Sany Katri	(707) 476-4714 FAX (707) 441-5600
13 Imperial County Department of Social Services 2995 South Fourth Street, Suite 105 El Centro, CA 92243	
Gloria Hernandez, Coordinator	(760) 337-6878 FAX (760) 337-5718
14 Inyo County Department of Social Services Drawer A Independence, CA 93526	
Pam Joseph	(760) 878-0300 FAX (760) 878-0266
15 Kern County Department of Human Services P.O. Box 511 Bakersfield, CA 93302	
Vicki Lay, Coordinator	(661) 631-6518 FAX (661) 633-7058
16 Kings County Human Services Agency 1200 South Drive Hanford, CA 93230	
Lupe Macias, Coordinator	(559) 582-3211 ext. 2227 FAX (559) 585-0346
17 Lake County Department of Social Services P.O. Box 9000 Lower Lake, CA 95457	
Rynda Murdock, Coordinator	(707) 995-4282 FAX (707) 995-4340
18 Lassen County Department of Social Services P.O. Box 1359 Susanville, CA 96130	
Yvonne Smith, Coordinator Karen Wheeler	(530) 251-8154 (530) 251-8372 FAX (530) 251-8370
19 Los Angeles County Department of Public Social Services 14714 Carmenita Boulevard Norwalk, CA 90650	
Stephanie Davis, Coordinator	(562) 623-2079
20 Madera County Department of Social Services P.O. Box 569 Madera, CA 93639-0569	
Marilyn Cheatham, Coordinator	(559) 675-7841 FAX (559) 675-7603

MC 171 (6/02) COUNTIES LISTING

Figure 3. Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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COUNTY/COORDINATOR	TELEPHONE NUMBER
21 Marin County Department of Health and Human Services Division of Social Services P.O. Box 4160, Civic Center Br San Rafael, CA 94913	
John Paul, Coordinator	(415) 499-7056 FAX (415) 499-6731
22 Mariposa County Department of Human Services P.O. Box 7 Mariposa, CA 95338	
Shana Long, Coordinator	(209) 966-3609 FAX (209) 966-5943
23 Mendocino County Department of Social Services P.O. Box 1759 825 Franklin Street Fort Bragg, CA 95437	
Bev Sipila	(707) 962-1144 FAX (707) 962-1010
24 Merced County Human Services Agency P.O. Box 112 Merced, CA 95341	
Kathy Southworth	(209) 385-3000 ext. 5789 FAX (209) 383-6925
25 Modoc County Department of Social Services 120 North Main Street Alturas, CA 96101	
Pat Wood, Coordinator	(530) 233-6504 FAX (530) 233-2136
26 Mono County Department of Social Services P.O. Box 2969 Mammoth Lakes, CA 93546	
Julie Timerman, Coordinator	(760) 934-3411 FAX (760) 924-5431
27 Monterey County Department of Social Services 1000 South Main Street, Suite 308 Salinas, CA 93901	
Veronica Wells, Coordinator	(831) 755-4675 FAX (831) 755-8476
28 Napa County Health and Human Services 2261 Elm Street Napa, CA 94559	
Mike Elroy, Coordinator	(707) 253-4598 FAX (707) 253-6095
29 Nevada County Human Services Agency 950 Maidu Avenue Nevada City, CA 95959	
Debbie Parman, Coordinator	(530) 265-1612 FAX (530) 265-7062
30 Orange County Department of Social Services 888 North Main Street, Bldg. 153 Santa Ana, CA 92701	
Marie Williams, Coordinator mwilliams@ssa.co.orange.ca.us	(714) 541-7867 FAX (714) 541-7855
31 Placer County Health and Human Services MIS Division 375 Nevada Street Auburn, CA 95603	
Penny James, Coordinator	(530) 886-4525 FAX (530) 886-4545
32 Plumas County Department of Social Services 270 County Hospital Road, Suite 207 Quincy, CA 95971-9126	
Betty Z. Cortez, Coordinator	(530) 283-6460 FAX (530) 283-6368
33 Riverside County Department of Public Social Services 4060 County Circle Drive Riverside, CA 92503	
Linda Avila	(909) 358-3057 FAX (909) 358 3389
34 Sacramento County Department of Human Assistance 3737 Marconi Avenue Sacramento, CA 95821-4807	
Diane Waite, Coordinator	(916) 875-3524 FAX (916) 875-3789
35 San Benito County Health and Human Services Agency 1111 San Felipe Road #206 Hollister, CA 95023	
Antoinette Moreno	(831) 636-4180 FAX (831) 637-9754
36 San Bernardino County Social Services Group 1950 Sunwest Lane, Third Floor San Bernardino, CA 92415-8515	
Sharon Williamson, Program Spec. I	(909) 388-0486 FAX (909) 387-8575
37 San Diego County Health and Human Services Agency 1700 Pacific Highway, W401 San Diego, CA 92101-7439	
Roxanne Brown	(858) 492-2236 FAX (858) 492-2265
38 San Francisco County Department of Social Services, S120 P.O. Box 7988 San Francisco, CA 94120-9939	
Tom Conrow, Coordinator	(415) 558-1953 FAX (415) 558-1976
39 San Joaquin County Human Services Agency 1111 North California Street Stockton, CA 95201-3006	
Donna Yim	(209) 468-8761 FAX (209) 468-2399
40 San Luis Obispo County Department of Social Services P.O. Box 8119 San Luis Obispo, CA 93401-8119	
Pauline Barnett, Coordinator	(805) 781-1903 FAX (805) 781-1846

MC 171 (6/02) COUNTIES LISTING

Figure 3 (continued). Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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COUNTY/COORDINATOR	TELEPHONE NUMBER
41 San Mateo County Human Services Agency 400 Harbor, Building C Belmont, CA 94002-4047	
Gail Akam, Coordinator	(650) 595-7534 FAX (650) 802-6490
42 Santa Barbara County Department of Social Services 2125 S. Centerpoint Parkway Santa Maria, CA 93455-1338	
Farrell Kisio, Coordinator	(805) 346-8217 FAX (805) 346-8366
1100 West Laurel Avenue Lompoc, CA 93436	
Barry McCampbell, Secur	(805) 346-7162 FAX (805) 737-7089
43 Santa Clara County Social Services Agency 1725 Technology Drive San Jose, CA 95110-1360	
Eddie Moth, Coordinator	(408) 441-5371 FAX (408) 436-0735
44 Santa Cruz County Human Resources Agency 1020 Emeline Street Santa Cruz, CA 96061	
Nyla Noroyan, Coordinator	(831) 454-4074 FAX (831) 454-4842
45 Shasta County Department of Social Services P.O. Box 496005 Redding, CA 96049	
Francine Orr, Coordinator	(530) 225-5589 FAX (530) 245-7630
46 Sierra County Human Services P.O. Box 1019 202 Front Street Loyalton, CA 96118	
Donna May, Coordinator	(530) 993-6720 FAX (530) 993-6767
47 Siskiyou County Human Services Department 818 South Main Street Yreka, CA 96097-9905	
Elizabeth Steward, Coordinator	(530) 841-4323 FAX (530) 841-2723
48 Solano County Health and Social Services Department P.O. Box 12000 355 Tuolumne Street Vallejo, CA 94590-9000	
Janet Stolling, Coordinator	(707) 553-5626 FAX (707) 553-5651
49 Sonoma County Human Services Department 520 Mendocino Avenue Santa Rosa, CA 95402-1539	
Tara Smith, Coordinator	(707) 565-5303 FAX (707) 565-5353

COUNTY/COORDINATOR	TELEPHONE NUMBER
50 Stanislaus County Community Services Agency P.O. Box 42 251 East Hackett Modesto, CA 95353	
Janet Sandoval, Coordinator	(209) 558-2592 FAX (209) 558-3310
51 Sutter County Welfare and Social Services P.O. Box 1535 Yuba City, CA 95992	
David Nagra, Coordinator	(530) 822-7230 ext. 206 FAX (530) 822-7212
52 Tehama County Department of Social Services P.O. Box 1515 22840 Antelope Boulevard Red Bluff, CA 96080	
Sandy Bruce, Coordinator	(530) 528-4090
53 Trinity County Health and Human Services Department P.O. Box 1470 #1 Industrial Parkway Weaverville, CA 96093	
Diane Darrah, Coordinator	(530) 623-8224 PUBLIC (530) 623-1265 FAX (530) 623-1250
54 Tulare County Health and Human Services Agency Public Social Services Branch 5957 South Mooney Boulevard Visalia, CA 93277	
Cheryl Cheek, Coordinator	(559) 737-4660 ext. 2107
55 Tuolumne County Department of Social Services 20075 Cedar Road North Sonora, CA 95370-5900	
Laurie Moore	(209) 533-5730 FAX (209) 533-0306
56 Ventura County Human Services Agency 505 Poli Street Ventura, CA 93001-2632	
Sylvia Pinuelas, Coordinator	(805) 652-7619 FAX (805) 652-7845
57 Yolo County Department of Employment and Social Services 25 North Cottonwood Woodland, CA 95695-2979	
Berlita McGrath berlita.mcgrath@ccm.yolocounty.org	(530) 661-2919 FAX (530) 661-2847
58 Yuba County Human Services P.O. Drawer 2320 6000 Lindhurst Avenue, #504 Marysville, CA 95901	
Jackie Watson, Coordinator	(530) 749-6321 FAX (530) 749-6797

MC 171 (6/02) COUNTIES LISTING

Figure 3 (continued). Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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LONG-TERM CARE FACILITY INFORMATION SHEET FOR PUBLIC ASSISTANCE OR MEDI-CAL RECIPIENTS

The long term care (LTC) facility to which you are being admitted must comply with various federal and state regulations in order for its services to be paid for by the Medi-Cal program. Please cooperate with the LTC facility in completing any federal and state forms that must be prepared. The information you provide on these forms will assist in ensuring that you receive all of the benefits to which you are entitled without any undue delays. The Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form (MC 171) which you have just been asked to complete is such a form.

The information you provide will be checked by computer with information provided by employers, banks, Social Security Administration, tax files, welfare, and other agencies.

California Code of Regulations, Title 22, Section 50185, says that as a Medi-Cal recipient you must report any changes in circumstances that might affect your eligibility for Medi-Cal no later than 10 calendar days following the date of the change. To assist you in reporting this type of change in your circumstances, the LTC facility will send the MC 171 to the appropriate Social Security Office and the county welfare department on you behalf. You are still responsible for ensuring that the proper action is taken in regard to your eligibility for Medi-Cal benefits, and therefore, if you do not hear from either SSA or the county within 45 days, please contact them immediately.

Depending on your individual situation, you may have to pay or obligate to pay a portion of your medical costs before Medi-Cal can pay for the rest of your care. This obligation is referred to as the recipient's share of cost. A worker from the county welfare department will determine whether you have a share of cost and the amount of any obligation now that you have entered an LTC facility. Persons in LTC facilities who have a share of cost pay or obligate the share of cost directly to the facility.

You have the right to a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health Services. If you wish to ask for a fair hearing, you must do so within 90 days after the date the notice of action was sent by the county or the date of the action with which you are dissatisfied.

To request a fair hearing, write to the Administrative Adjudication Division, Department of Social Services, 744 P Street, Sacramento, CA 95814. You may also request a fair hearing by calling Toll Free: 800-952-5253.

If you want a family member to act on your behalf or you have any question or need other services, please contact your county welfare department for assistance.

Information Notice 006A

Figure 4. Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A).

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Discharge to Home

Figure 5. Discharge to home

This is a sample only. Please adapt to your billing situation.

In this example, a patient was admitted to an NF-B on October 11, 2015, and remained until October 31, 2015. Therefore on line 1, "101115" and "103115" are entered in the *Dates of Service* fields (Boxes 12 and 13).

During this billing period, the patient's status is noted as "01" (patient admitted) in the *Patient Status* field (Box 14). See the *Payment Request for Long Term Care (25-1) Completion* section for more information about patient status codes.

Because the billing period is for 20 days at the NF-B per diem rate of $109.53, the gross amount $2190.60 is entered in the *Gross Amount* field (Box 17).

Because this claim is submitted with a diagnosis code, an ICD indicator is required as an additional digit before the ICD-10-CM code in the *Primary DX Code* field (Boxes 16 and 36). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

On November 6, 2015, the patient was discharged to home. The date of service period extended from November 1, 2015, through November 6, 2015, and is entered on line 2 in the *Date of Service* field (Boxes 31 and 32). During this billing period, the patient's status is noted as "04" (patient discharged to home) in the *Patient Status* field (Box 33).

This billing period is calculated based on six days minus one day for discharge at the NF-B per diem rate of $109.53. The gross amount, $547.65, is entered in the *Gross Amount* field (Box 36).

Also, because these services require a *Treatment Authorization Request* (TAR), the nine-digit TAR Control Number (TCN) is entered in the *TAR Control No.* field (Boxes 8 and 27).

See the *Payment Request for Long Term Care (25-1) Completion* section of this manual for more information about completing fields 119 and 127.

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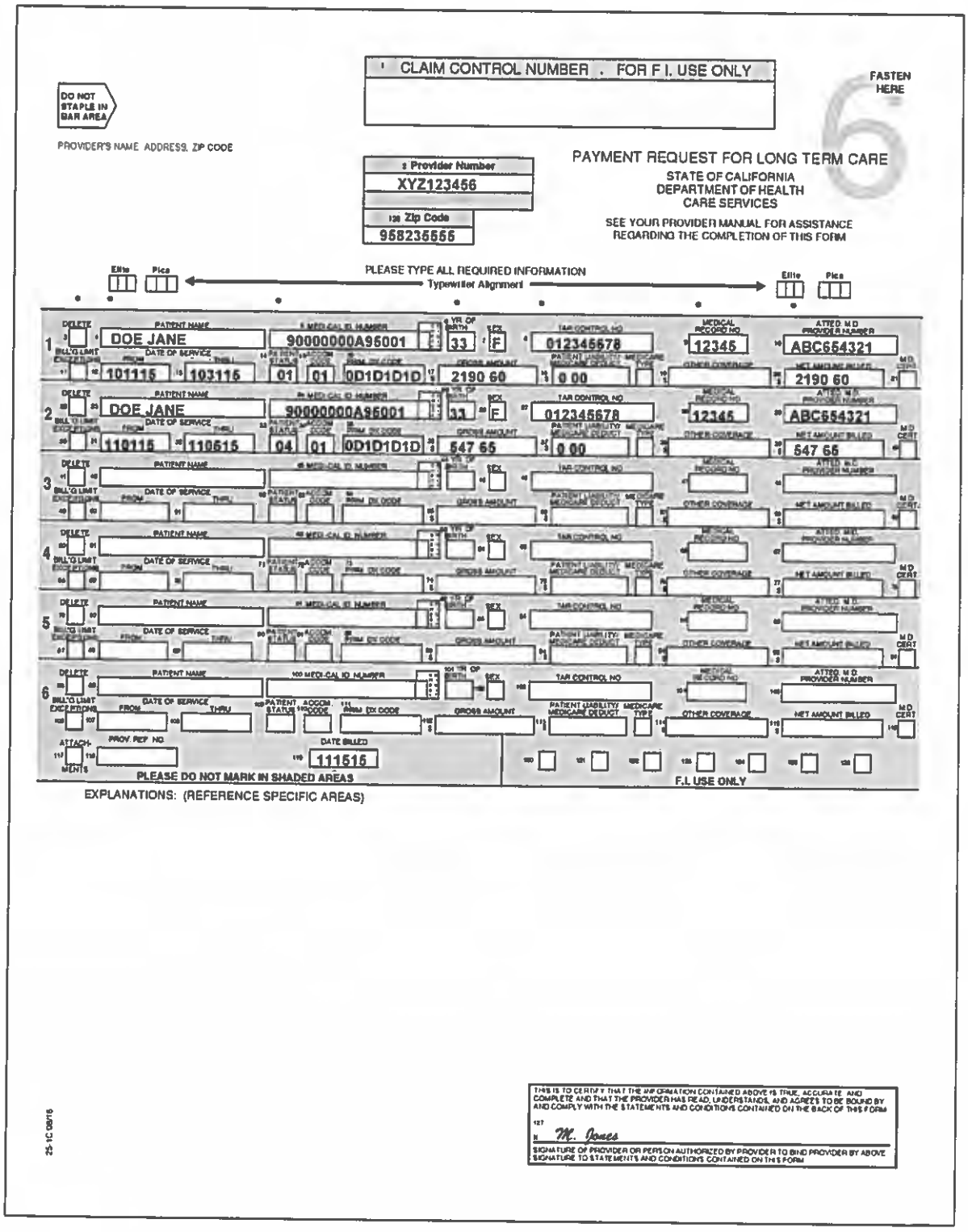

Figure 5. Discharge to Home.

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Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*ADULT SUBACUTE PROGRAM*

To expedite your request for authorization/reauthorization of SUBACUTE CARE SERVICES, it is **essential** that you complete the information below. Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4. Diagnosis			
5. Medi-Cal Identification Number	6. Current level of care	Date of admission	
7. Name of current provider of above level of care			
Address (number, street)	City	State	ZIP Code
8. Family name		Telephone ( )	
Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse; **and**, ... ☐ ☐
please summarize care requirements each shift: _____

b. **One** of the following (1), (2), (3):

(1) Patient has a tracheostomy and requires mechanical ventilation at least 50 percent of the day. ..... ☐ ☐

(2) Patient has a tracheostomy and requires suctioning and room air mist or oxygen **and** one of the treatment procedures listed below (check all that apply). ☐ ☐

- ☐ (a) Total Parenteral Nutrition (TPN)
- ☐ (b) Inpatient physical, occupational, and/or speech therapy at least two hours per day, five days per week.
- ☐ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____
- ☐ (d) Inhalation/respiratory therapy treatments at least 4 times per 24-hour period (not self administered by resident).
- ☐ (e) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
  Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____
- ☐ (f) Wound debridement, packing, and medicated irrigation with/without whirlpool therapy.
  Please explain: _____

(3) Administration of any three of the treatment procedures in b (2) (a) through (f) above. Please check all that apply. ☐ ☐

c. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

d. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

e. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

10. Authorized signature	11. Date

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to the local Medi-Cal field office when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the local Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, federal regulations require that the provider continue to complete the MDS and place in the resident's charts. To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification Number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** per Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

a–b. (4): Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

c. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

d. **Reauthorizations:** Complete this only if this is a ***reauthorization*** for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

e. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*PEDIATRIC SUBACUTE PROGRAM*

❒ Initial ❒ Reauthorization ❒ Transfer

Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary	2. Birthdate	3. Age

4.Primary Diagnosis (and any secondary diagnoses pertinent to the level of care)

5. Medi-Cal Identification Number	6. Current level of care	Date of admission

7. Name of current provider of above level of care

Address (number, street)	City	State	ZIP Code

8. Family name	Telephone ( )

Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for PEDIATRIC SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse and is under 21 years of age; and ❒ ❒

b. One of the following (1), (2), (3), (4), or (5):

(1) Patient has a tracheostomy and requires mechanical ventilation at least six hours per day. ..... ❒ ❒

(2) Patient has a tracheostomy and requires suctioning at least every six hours and room air mist or oxygen; **and** one of the treatment procedures listed below (check all that apply). ❒ ❒

❒ (a) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____

_____

❒ (b) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.

❒ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____

❒ (d) Other daily medical technologies required continuously which, in the opinion of the attending physician and the Medi-Cal consultant, require the services of a professional nurse.
Please summarize care requirements each shift: _____

_____

❒ (e) Dependence on biphasic positive airway pressure at least six hours a day, including assessment or intervention every three hours, where the patient lacks either the cognitive or physical ability to protect their airway.

(3) Dependence on total parenteral nutrition (TPN) or other intravenous nutritional support; **and** one of the treatment procedures listed above in (2) (a) through (e); including (f) below (check all that apply). ❒ ❒

❒ (f) Intermittent suctioning (nontracheostomy) at least every eight hours, **and** room air mist or oxygen.

(4) Dependence on skilled nursing care in the administration of any three of the treatment procedures in a (2) (a) through (e), including (3) (f) listed above. Please check all that apply. ❒ ❒

(5) Dependence on biphasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures specified in a (2) (a) through (e), including (3) (f) above. ❒ ❒

b. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

_____

c. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

d. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

_____

10. Authorized signature	11. Date

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—PEDIATRIC SUBACUTE PROGRAM

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to Medi-Cal TAR Processing Center when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, Federal regulations require that the provider continue to complete the MDS and place in the resident's charts.

Please indicate in one of the boxes under the title if this is an initial TAR for subacute care, a reauthorization for subacute care, or the patient is being transferred from another facility or home.

To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** Welfare & Institutions Code 14132.25; Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

   a. (1) – (5) : Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

   b. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

   c. **Reauthorizations:** Complete this only if this is a *reauthorization* for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

   d. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

Policy:	GG.1804
Title:	**Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	06/01/98
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the criteria for authorizing a Member's admission to, continued stay in, or discharge from a qualified, Out-of-Network Subacute, Long-Term Care Nursing Facility Level A (NF-A) and Level B (NF-B).

II. POLICY

A. CalOptima shall authorize room and board services for a Member's admission to, continued stay in, or discharge from, an Out-of-Network Qualified Subacute, Long-Term Care NF-A and NF-B Facility under any of the following conditions:

1. The placement is court ordered, or under the direction of a court appointed conservator; or

2. The placement is intended for short-term rehabilitation, or stabilization, until such time that travel will not jeopardize the Member's health.

B. If nursing facility beds are not available within CalOptima's network, CalOptima shall enter into a Letter of Agreement (LOA) or contract with an Out-of- Network Qualified Nursing Facility, in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

C. If a Member resides in an Out-of-Network Long-Term Care Nursing Facility prior to enrollment, the Member shall remain in the Facility in accordance with CalOptima Policies CMC.6021a: Continuity of Care for New Members, and GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

D. The CalOptima Long Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a Subacute –Adult, Subacute-Pediatric, NF-A and NF-B Facilities pursuant to Title 22, California Code of Regulations, §§51334, 51335, 51511 and the Department of Health Care Services (DHCS) standard clinical criteria for level of care.

E. If CalOptima is unable to render a decision within the required timeframe, it shall be considered a denial. CalOptima will notify the subacute, NF-A or NF-B facility in accordance with CalOptima Policies GG. 1814: Appeals Process for Long Term Care Facility and GG.1510: Appeal Process.

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F. CalOptima shall limit authorization to a Subacute-Adult, Subacute–Pediatric, NF-A and NF-B Facilities, that are licensed and certified by the California Department of Public Health (CDPH) and approved by the Department of Health Care Services (DHCS), in accordance with State and Federal regulations, and contracted with CalOptima in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

III. PROCEDURE

A. A nursing facility shall notify the CalOptima LTSS Department by facsimile, mail, or telephone, of a Member's admission to a Subacute-Adult, Subacute-Pediatric, NF-A or NF-B facilities in accordance with CalOptima Policies GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B) and GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric.

B. The NF-A and NF-B facilities shall submit a reauthorization request prior to the expiration of the active Long-Term Care (LTC) Authorization. The facility may submit the reauthorization request up to sixty (60) calendar days prior to expiration of the active Authorization. The reauthorization requests shall include a completed LTC ARF (Sections I, III, and IV) signed by the Physician, and medical records sufficient to determine the level of care and justify continued stay.

C. A Subacute Facility shall submit a reauthorization request prior to the expiration of the active LTC Authorization. The facility may submit the reauthorization request up to thirty (30) calendar days prior to expiration of the active LTC Authorization. The authorization requests shall include a copy of a signed MD Order for admission to the nursing facility or an ARF with MD signature and Section I, III and IV completed on the ARF. A signed 6200-A/6200 form, and medical records sufficient to determine the level of care and justify a continued stay must be included with the completed ARF.

D. CalOptima shall utilize the DHCS standard clinical criteria in the LTC ARF evaluation process as stated in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long Term Care Services.

E. If the LTC ARF and required attachments are incomplete, the Subacute, NF-A or NF-B Facility will be requested to resubmit ARF with additional requested information within fourteen (14) calendar days. If the nursing facility does not provide the requested documents after the initial fourteen (14) calendar days of the authorization request, the request shall be subject to denial. An extension of fourteen (14) calendar days may be granted if the Member or Member's Physician requests the extension; or the CalOptima Nurse Case Manager justifies a need for additional information and if the extension is in the Member's best interest. The extension period is to allow the Nursing Facility time to collect required documentation (*e.g.,* specialist consults, additional tests required, etc.).The CalOptima Nurse Case Manager will document the need for extension and how it is in the member's best interest in the member's electronic medical record.

F. The CalOptima LTSS Department shall issue a deferral notice (Delay letter) if CalOptima LTSS Department extends the timeframe an additional fourteen (14) calendar days, up to a maximum of twenty-eight (28) calendar days total from the day of initial notification.

G. Upon receipt of all information reasonably necessary and requested, CalOptima LTSS Department shall approve, modify, or deny the request for authorization within five (5) business days.

H. If the CalOptima LTSS Department is unable to approve the LTC ARF due to insufficient documentation of Medical Necessity, the CalOptima LTSS Department shall submit the LTC ARF

and accompanying documentation to the CalOptima Medical Director, or physician Designee, for review and determination.

1. If CalOptima's Medical Director, or physician Designee, approves the LTC ARF, the CalOptima LTSS Department shall send a copy of the approved LTC ARF to the Facility.

2. If CalOptima's Medical Director, or physician Designee, denies the LTC ARF, the CalOptima LTSS Department shall notify the Subacute, NF-A or NF-B Facility within one business day, and the Member or Member's Authorized Representative within two business days in accordance with CalOptima Policies GG.1814: Appeals Process for Long Term Care Facility and GG.1510: Appeal Process.

I. Upon notification by the Nursing Facility of the Member's discharge, the CalOptima LTSS Department shall close the active LTC ARF effective the day of discharge:

1. The Nursing Facility shall notify CalOptima within one (1) business days of a Member's discharge by sending the Nursing Facility "Discharge Disposition Form" to the LTSS department.

2. The nursing facility shall send the Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agencies.

J. CalOptima's LTSS Department shall notify the appropriate departments, and Health Network, for further Care Coordination.

IV. ATTACHMENT(S)

A. CalOptima Long Term Care Authorization Request Form (ARF)
B. CalOptima Nursing Facility Discharge Disposition Form
C. Medi-Cal LTC Facility Discharge Notification Form (MC171)
D. Information for Authorization/Reauthorization of Subacute Care Services-Adult Subacute Program (DHCS 6200-A)
E. Information for Authorization/Reauthorization of Subacute Care Services-Pediatric Subacute Program (DHCS 6200).

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Policy CMC.6021a: Continuity of Care for New Members
D. CalOptima Policy EE.1135: Long Term Care Facility Contracting
E. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
F. CalOptima Policy GG.1510: Appeal Process
G. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
H. CalOptima Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in and Discharge from a Subacute Facility-Adult/Pediatric.
I. CalOptima Policy GG.1814: Appeals Process for Long Term Care Facility
J. CalOptima Utilization Management Program

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K. Department of Health Care Services All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "YOUR RIGHTS" Attachments
L. CMS Nursing Home Quality Initiative MDS for Nursing Homes and Swing Bed Providers
M. Manual of Criteria for Medi-Cal Authorizations, Medi-Cal Policy Division
N. Medi-Cal Provider Manual, Section: Admissions and Discharges
O. Title 22, California Code of Regulations (CCR.), §§51006, 51120, 51121, 51124, 51212, 51134, 51335, and 51511
P. Welfare and Institutions Code, §14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/16	Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Skilled Nursing Facilities (SNF)	Medi-Cal
Revised	07/15/1998	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Skilled Nursing Facilities	Medi-Cal
Revised	02/01/2007	GG.1804	Admission to, Continued Stay in, and Discharge From Out-of State Skilled Nursing Facilities	Medi-Cal
Revised	02/01/2016	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-State Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised	08/01/2016	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2017	GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect
Revised		GG.1804	Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: 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. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Long-Term Care Nursing Facility	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.
Member	An enrollee-beneficiary of a CalOptima Program.
Nursing Facility Level A (NF-A)	Nursing Facility Level A (NF-A) is known as the Intermediate Care level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Nursing Facility Level B (NF-B) is known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Out-of- Network	For purposes of this policy, refers to a Non-Contracted Long-Term Care Facility Provider
Qualified Nursing Facility	For purposes of this policy, refers to Subacute, Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B). The facility is licensed by the State, meets acceptable quality standards and accepts Medicaid rates for Medicaid services and Medicare rates for Medicare services.
Subacute Facility	For purposes of this policy, refers to Subacute Adult and Pediatric facilities.

Term	Definition
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.8 as an identifiable unit of a SNF accommodating beds including continuous room, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Tile 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

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CalOptima
A Public Agency
Better. Together.
P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Denied ☐ Approved as Modified ☐ Deferred
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:
- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:
- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes
- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

Admissions and Discharges

This section describes admission and discharge procedures for Long Term Care (LTC) facilities.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

Medi-Cal Long Term Care Facility Admission and Discharge Form (MC 171)

NF-As and NF-Bs are required to complete the *Medi-Cal Long Term Care Facility Admission and Discharge Notification* (MC 171) form on admission or discharge of a patient. (See *Figures 1* thru *3* on a following page in this section.)

Admission Procedures

On admission to an LTC facility, a Medi-Cal recipient or the recipient's representative must complete the *Medi-Cal Long Term Care Facility Admission and Discharge Notification* (MC 171) form, Parts I and II.

The MC 171 must have the original signature of the recipient. If the recipient's signature cannot be obtained (for example, in the case of a comatose recipient), the facility representative must indicate the reason the recipient's signature cannot be obtained.

Supplemental Security Income Recipients

When a Supplemental Security Income (SSI) recipient enters a Nursing Facility (NF), providers must notify a Social Security Administration (SSA) field office of the recipient's name, Social Security Number (SSN) and date of entry. SSI recipients are required to report their status to the provider when entering an NF.

Form Submission to Government Agencies

The LTC facility must retain a copy of the MC 171 for its files and send either the original or a copy to the proper government agencies depending on whether:

- A patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP). The original MC 171 should be sent to the local Social Security Office. The aid code for these recipients is 10, 20 or 60. A copy of the MC 171 should be forwarded to the local county welfare department.
- A patient receives aid under any program other than SSI/SSP. The original MC 171 should be sent to the local county welfare department. The aid code for these recipients will be other than 10, 20 or 60.

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Form Submission Not Required by DHCS, Medi-Cal Eligibility Division	The LTC facility is not required to submit a copy of the MC 171 form to the Department of Health Care Services (DHCS), Medi-Cal Eligibility Division. The Medi-Cal consultant will use the recipient's initial *Treatment Authorization Request* (TAR) as notification of the patient's admission.
Routine or Standing Orders – Hospitals and Skilled Nursing Facilities	Services billed to Medi-Cal that are the result of routine or standing orders for admission to a hospital or NF-B are not payable when applied indiscriminately to all patients. All patient orders, including standing orders for particular types of cases, must be specific to the patient and must represent necessary medical care for the diagnosis or treatment of a particular condition Claims for routine orders will be subject to audit for medical necessity and will be denied if not justified by the facts relating to the case or if in excess of current patient needs The use of routine or standing orders is discouraged by the American College of Surgeons, the California Medical Association, the California Association of Hospitals and Health Systems, the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association.
Discharge Procedures	When a patient receiving NF-A or NF-B expires or is discharged from an LTC facility, the facility must complete Part III of the MC 171 and submit the original to the county welfare department. Send a copy of the MC 171 to the TAR Processing Center only when submitting a TAR for dates of service prior to discharge (with the exception of bedhold TARs).
Discharge/Death on Day of Admission	If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable.

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Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A)

The *Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients* (MC 171A) form is an information sheet for facilities to use to advise SSI/SSP and Medi-Cal-only recipients of the need to complete the MC 171 (see *Figure 4* on a following page in this section). The form also explains a recipient's Share of Cost and the need to inform SSA and county welfare departments of a change in status.

Ordering Forms

Refer to the *Forms Reorder Request: Long Term Care* section in this manual for ordering information.

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

MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

(Instructions and distribution on reverse)

I. COMPLETE THIS PORTION FOR ALL ACTIONS

Patient's name (last) (first) (MI)

Name of facility

Social security number

Address (number and street)

Note: Level of care is SNF/ICF unless checked here as board and care ☐

City State ZIP code

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

Medi-Cal ID number (taken from the Medi-Cal card)

Admission date (month/day/year)

A. Do you have Medicare Part A, Hospital Coverage?
☐ Yes ☐ No

B. Expected length of stay:
☐ At least one full month after the month of admission
☐ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.
☐ Yes, beginning with month of _____, 20
☐ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):
☐ Supplemental Security Gold Checks
☐ Social Security Green Checks
☐ Other Income (i.e., railroad, military retirement, etc.)
☐ None

E. Admission from:
☐ Home ☐ Board and Care
☐ Household of another
☐ Acute Hospital— Home, B&C, other household immediately prior to acute
☐ Acute Hospital— SNF/ICF immediately prior to acute
☐ Acute Hospital extended stay— over 30 days
☐ Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital's address.)

Address (number and street)

City State ZIP code

G. Signature of recipient or representative payee or family member/other:

Signature of recipient

Signature of Representative Payee

Phone number

If recipient's signature cannot be obtained, please indicate reason in this space.

Signature of family member/other (indicate your relationship to the recipient.)

Phone number

III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:
☐ Discharged to Acute Hospital
☐ Discharged to another SNF/ICF
☐ Discharged to residence/home of another
☐ Discharged to Board and Care
☐ Discharged to other
☐ Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

Facility representative signature

Date

MC 171 (6/02)

Figure 1. Long Term Care Facility Admission and Discharge Notification (MC 171) Form.

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I. General Instructions

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local social security office for recipients with aid codes 10, 20, and 60. Send to the county welfare department (see attached list) for all other aid codes.

Copy 1: Attach to the Treatment Authorization Request (TAR) and send to the Department of Health Services, Medi-Cal field office in your area. It will be forwarded by the Medi-Cal field office to the county welfare department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use copy two of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal field office.

Copy 1: Send to the county welfare department (see attached list).

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in item II.C. of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a "YES" response would be indicated for item II.C. if Medi-Cal is expected to pay over $450 of the $900 charge for February.

MC 171 (6/02)

Figure 2. Long Term Care Facility Admission and Discharge Notification (MC 171) Form (Back).

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COUNTY/COORDINATOR	TELEPHONE NUMBER
01 Alameda County Social Services Agency P.O. Box 12941 Oakland, CA 94604	
Liz Blankenship	(510) 777-2343 FAX (510) 777-2310
02 Alpine County Department of Social Services 75 A Diamond Valley Road Markleeville, CA 96120	
Cami Chavez, Coordinator	(530) 694-2235 FAX (530) 694-2252
03 Amador County Department of Social Services 1003 Broadway Jackson, CA 95642	
Pattie Edmunds	(209) 223-6642 FAX (209) 223-6579
04 Butte County Department of Employment and Social Services P.O. Box 1649 Oroville, CA 95965-1649	
Carol Kuopus, Coordinator	(530) 538-3713 FAX (530) 538-4328
05 Calaveras County Social Welfare Department 891 Mountain Ranch Road San Andreas, CA 95249-9709	
Connie McLain	(209) 754-6447 FAX (209) 754-6724
06 Colusa County Department of Social Welfare P.O. Box 370 Colusa, CA 95932	
Sharon Carvalho	(530) 458-0275
07 Contra Costa County Employment and Human Services 40 Douglas Drive Martinez, CA 94553	
Daniel Chan	(925) 313-1619 FAX (925) 313-1710
08 Del Norte County Department of Social Services 880 Northcrest Drive Crescent City, CA 95531-3485	
Mary Yingst, Coordinator	(707) 464-3191 FAX (707) 465-1783
09 El Dorado County Department of Social Services 3057 Briw Road Placerville, CA 95667	
Lori Ogden	(530) 642-7323 FAX (530) 295-2724
10 Fresno County Department of Employment and Temporary Assistance 4944 E. Clinton Way, Suite 112 Fresno, CA 93750-0001	
Nancy Gillitzer	(559) 253-9271 FAX (559) 253-9250
11 Glenn County Human Resources Agency P.O. Box 611 420 East Laurel Street Willows CA 95988-0611	
Lily Montz, Coordinator	(530) 934-6514 ext. 139 FAX (530) 934-6521
12 Humboldt County Department of Health and Human Services 929 Koster Street Eureka, CA 95501	
Sany Katri	(707) 476-4714 FAX (707) 441-5600
13 Imperial County Department of Social Services 2995 South Fourth Street, Suite 105 El Centro, CA 92243	
Gloria Hernandez, Coordinator	(760) 337-6878 FAX (760) 337-5718
14 Inyo County Department of Social Services Drawer A Independence, CA 93526	
Pam Joseph	(760) 878-0300 FAX (760) 878-0266
15 Kern County Department of Human Services P.O. Box 511 Bakersfield, CA 93302	
Vicki Lay, Coordinator	(661) 631-6518 FAX (661) 633-7058
16 Kings County Human Services Agency 1200 South Drive Hanford, CA 93230	
Lupe Macias, Coordinator	(559) 582-3211 ext. 2227 FAX (559) 585-0346
17 Lake County Department of Social Services P.O. Box 9000 Lower Lake, CA 95457	
Rynda Murdock, Coordinator	(707) 995-4282 FAX (707) 995-4340
18 Lassen County Department of Social Services P.O. Box 1359 Susanville, CA 96130	
Yvonne Smith, Coordinator Karen Wheeler	(530) 251-8154 (530) 251-8372 FAX (530) 251-8370
19 Los Angeles County Department of Public Social Services 14714 Carmenita Boulevard Norwalk, CA 90650	
Stephanie Davis, Coordinator	(562) 623-2079
20 Madera County Department of Social Services P.O. Box 569 Madera, CA 93639-0569	
Marilyn Cheatham, Coordinator	(559) 675-7841 FAX (559) 675-7603

MC 171 (6/02) COUNTIES LISTING

Figure 3. Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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COUNTY/COORDINATOR	TELEPHONE NUMBER
21 Marin County Department of Health and Human Services Division of Social Services P.O. Box 4160, Civic Center Br San Rafael, CA 94913	
John Paul, Coordinator	(415) 499-7056 FAX (415) 499-6731
22 Mariposa County Department of Human Services P.O. Box 7 Mariposa, CA 95338	
Shana Long, Coordinator	(209) 966-3609 FAX (209) 966-5943
23 Mendocino County Department of Social Services P.O. Box 1759 825 Franklin Street Fort Bragg, CA 95437	
Bev Sipila	(707) 962-1144 FAX (707) 962-1010
24 Merced County Human Services Agency P.O. Box 112 Merced, CA 95341	
Kathy Southworth	(209) 385-3000 ext. 5789 FAX (209) 383-6925
25 Modoc County Department of Social Services 120 North Main Street Alturas, CA 96101	
Pat Wood, Coordinator	(530) 233-6504 FAX (530) 233-2136
26 Mono County Department of Social Services P.O. Box 2969 Mammoth Lakes, CA 93546	
Julie Timerman, Coordinator	(760) 934-3411 FAX (760) 924-5431
27 Monterey County Department of Social Services 1000 South Main Street, Suite 308 Salinas, CA 93901	
Veronica Wells, Coordinator	(831) 755-4675 FAX (831) 755-8476
28 Napa County Health and Human Services 2261 Elm Street Napa, CA 94559	
Mike Elroy, Coordinator	(707) 253-4598 FAX (707) 253-6095
29 Nevada County Human Services Agency 950 Maidu Avenue Nevada City, CA 95959	
Debbie Parman, Coordinator	(530) 265-1612 FAX (530) 265-7062
30 Orange County Department of Social Services 888 North Main Street, Bldg. 153 Santa Ana, CA 92701	
Marie Williams, Coordinator mwilliams@ssa.co.orange.ca.us	(714) 541-7867 FAX (714) 541-7855
31 Placer County Health and Human Services MIS Division 375 Nevada Street Auburn, CA 95603	
Penny James, Coordinator	(530) 886-4525 FAX (530) 886-4545
32 Plumas County Department of Social Services 270 County Hospital Road, Suite 207 Quincy, CA 95971-9126	
Betty Z. Cortez, Coordinator	(530) 283-6460 FAX (530) 283-6368
33 Riverside County Department of Public Social Services 4060 County Circle Drive Riverside, CA 92503	
Linda Avila	(909) 358-3057 FAX (909) 358 3389
34 Sacramento County Department of Human Assistance 3737 Marconi Avenue Sacramento, CA 95821-4807	
Diane Waite, Coordinator	(916) 875-3524 FAX (916) 875-3789
35 San Benito County Health and Human Services Agency 1111 San Felipe Road #206 Hollister, CA 95023	
Antoinette Moreno	(831) 636-4180 FAX (831) 637-9754
36 San Bernardino County Social Services Group 1950 Sunwest Lane, Third Floor San Bernardino, CA 92415-8515	
Sharon Williamson, Program Spec. I	(909) 388-0486 FAX (909) 387-8575
37 San Diego County Health and Human Services Agency 1700 Pacific Highway, W401 San Diego, CA 92101-7439	
Roxanne Brown	(858) 492-2236 FAX (858) 492-2265
38 San Francisco County Department of Social Services, S120 P.O. Box 7988 San Francisco, CA 94120-9939	
Tom Conrow, Coordinator	(415) 558-1953 FAX (415) 558-1976
39 San Joaquin County Human Services Agency 1111 North California Street Stockton, CA 95201-3006	
Donna Yim	(209) 468-8761 FAX (209) 468-2399
40 San Luis Obispo County Department of Social Services P.O. Box 8119 San Luis Obispo, CA 93401-8119	
Pauline Barnett, Coordinator	(805) 781-1903 FAX (805) 781-1846

MC 171 (6/02) COUNTIES LISTING

Figure 3 (continued). Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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COUNTY/COORDINATOR	TELEPHONE NUMBER
41 San Mateo County Human Services Agency 400 Harbor, Building C Belmont, CA 94002-4047	
Gail Akam, Coordinator	(650) 595-7534 FAX (650) 802-6490
42 Santa Barbara County Department of Social Services 2125 S. Centerpoint Parkway Santa Maria, CA 93455-1338	
Farrell Kisio, Coordinator	(805) 346-8217 FAX (805) 346-8366
1100 West Laurel Avenue Lompoc, CA 93436	
Barry McCampbell, Secur	(805) 346-7162 FAX (805) 737-7089
43 Santa Clara County Social Services Agency 1725 Technology Drive San Jose, CA 95110-1360	
Eddie Moth, Coordinator	(408) 441-5371 FAX (408) 436-0735
44 Santa Cruz County Human Resources Agency 1020 Emeline Street Santa Cruz, CA 96061	
Nyla Noroyan, Coordinator	(831) 454-4074 FAX (831) 454-4842
45 Shasta County Department of Social Services P.O. Box 496005 Redding, CA 96049	
Francine Orr, Coordinator	(530) 225-5589 FAX (530) 245-7630
46 Sierra County Human Services P.O. Box 1019 202 Front Street Loyalton, CA 96118	
Donna May, Coordinator	(530) 993-6720 FAX (530) 993-6767
47 Siskiyou County Human Services Department 818 South Main Street Yreka, CA 96097-9905	
Elizabeth Steward, Coordinator	(530) 841-4323 FAX (530) 841-2723
48 Solano County Health and Social Services Department P.O. Box 12000 355 Tuolumne Street Vallejo, CA 94590-9000	
Janet Stolling, Coordinator	(707) 553-5626 FAX (707) 553-5651
49 Sonoma County Human Services Department 520 Mendocino Avenue Santa Rosa, CA 95402-1539	
Tara Smith, Coordinator	(707) 565-5303 FAX (707) 565-5353

COUNTY/COORDINATOR	TELEPHONE NUMBER
50 Stanislaus County Community Services Agency P.O. Box 42 251 East Hackett Modesto, CA 95353	
Janet Sandoval, Coordinator	(209) 558-2592 FAX (209) 558-3310
51 Sutter County Welfare and Social Services P.O. Box 1535 Yuba City, CA 95992	
David Nagra, Coordinator	(530) 822-7230 ext. 206 FAX (530) 822-7212
52 Tehama County Department of Social Services P.O. Box 1515 22840 Antelope Boulevard Red Bluff, CA 96080	
Sandy Bruce, Coordinator	(530) 528-4090
53 Trinity County Health and Human Services Department P.O. Box 1470 #1 Industrial Parkway Weaverville, CA 96093	
Diane Darrah, Coordinator	(530) 623-8224 PUBLIC (530) 623-1265 FAX (530) 623-1250
54 Tulare County Health and Human Services Agency Public Social Services Branch 5957 South Mooney Boulevard Visalia, CA 93277	
Cheryl Cheek, Coordinator	(559) 737-4660 ext. 2107
55 Tuolumne County Department of Social Services 20075 Cedar Road North Sonora, CA 95370-5900	
Laurie Moore	(209) 533-5730 FAX (209) 533-0306
56 Ventura County Human Services Agency 505 Poli Street Ventura, CA 93001-2632	
Sylvia Pinuelas, Coordinator	(805) 652-7619 FAX (805) 652-7845
57 Yolo County Department of Employment and Social Services 25 North Cottonwood Woodland, CA 95695-2979	
Berlita McGrath berlita.mcgrath@ccm.yolocounty.org	(530) 661-2919 FAX (530) 661-2847
58 Yuba County Human Services P.O. Drawer 2320 6000 Lindhurst Avenue, #504 Marysville, CA 95901	
Jackie Watson, Coordinator	(530) 749-6321 FAX (530) 749-6797

MC 171 (6/02) COUNTIES LISTING

Figure 3 (continued). Long Term Care Facility Admission and Discharge Notification (MC 171) Form – County Welfare Departments.

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LONG-TERM CARE FACILITY INFORMATION SHEET FOR PUBLIC ASSISTANCE OR MEDI-CAL RECIPIENTS

The long term care (LTC) facility to which you are being admitted must comply with various federal and state regulations in order for its services to be paid for by the Medi-Cal program. Please cooperate with the LTC facility in completing any federal and state forms that must be prepared. The information you provide on these forms will assist in ensuring that you receive all of the benefits to which you are entitled without any undue delays. The Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form (MC 171) which you have just been asked to complete is such a form.

The information you provide will be checked by computer with information provided by employers, banks, Social Security Administration, tax files, welfare, and other agencies.

California Code of Regulations, Title 22, Section 50185, says that as a Medi-Cal recipient you must report any changes in circumstances that might affect your eligibility for Medi-Cal no later than 10 calendar days following the date of the change. To assist you in reporting this type of change in your circumstances, the LTC facility will send the MC 171 to the appropriate Social Security Office and the county welfare department on you behalf. You are still responsible for ensuring that the proper action is taken in regard to your eligibility for Medi-Cal benefits, and therefore, if you do not hear from either SSA or the county within 45 days, please contact them immediately.

Depending on your individual situation, you may have to pay or obligate to pay a portion of your medical costs before Medi-Cal can pay for the rest of your care. This obligation is referred to as the recipient's share of cost. A worker from the county welfare department will determine whether you have a share of cost and the amount of any obligation now that you have entered an LTC facility. Persons in LTC facilities who have a share of cost pay or obligate the share of cost directly to the facility.

You have the right to a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health Services. If you wish to ask for a fair hearing, you must do so within 90 days after the date the notice of action was sent by the county or the date of the action with which you are dissatisfied.

To request a fair hearing, write to the Administrative Adjudication Division, Department of Social Services, 744 P Street, Sacramento, CA 95814. You may also request a fair hearing by calling Toll Free: 800-952-5253.

If you want a family member to act on your behalf or you have any question or need other services, please contact your county welfare department for assistance.

Information Notice 006A

Figure 4. Long Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A).

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Discharge to Home

Figure 5. Discharge to home

This is a sample only. Please adapt to your billing situation.

In this example, a patient was admitted to an NF-B on October 11, 2015, and remained until October 31, 2015. Therefore on line 1, "101115" and "103115" are entered in the *Dates of Service* fields (Boxes 12 and 13).

During this billing period, the patient's status is noted as "01" (patient admitted) in the *Patient Status* field (Box 14). See the *Payment Request for Long Term Care (25-1) Completion* section for more information about patient status codes.

Because the billing period is for 20 days at the NF-B per diem rate of $109.53, the gross amount $2190.60 is entered in the *Gross Amount* field (Box 17).

Because this claim is submitted with a diagnosis code, an ICD indicator is required as an additional digit before the ICD-10-CM code in the *Primary DX Code* field (Boxes 16 and 36). An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

On November 6, 2015, the patient was discharged to home. The date of service period extended from November 1, 2015, through November 6, 2015, and is entered on line 2 in the *Date of Service* field (Boxes 31 and 32). During this billing period, the patient's status is noted as "04" (patient discharged to home) in the *Patient Status* field (Box 33).

This billing period is calculated based on six days minus one day for discharge at the NF-B per diem rate of $109.53. The gross amount, $547.65, is entered in the *Gross Amount* field (Box 36).

Also, because these services require a *Treatment Authorization Request* (TAR), the nine-digit TAR Control Number (TCN) is entered in the *TAR Control No.* field (Boxes 8 and 27).

See the *Payment Request for Long Term Care (25-1) Completion* section of this manual for more information about completing fields 119 and 127.

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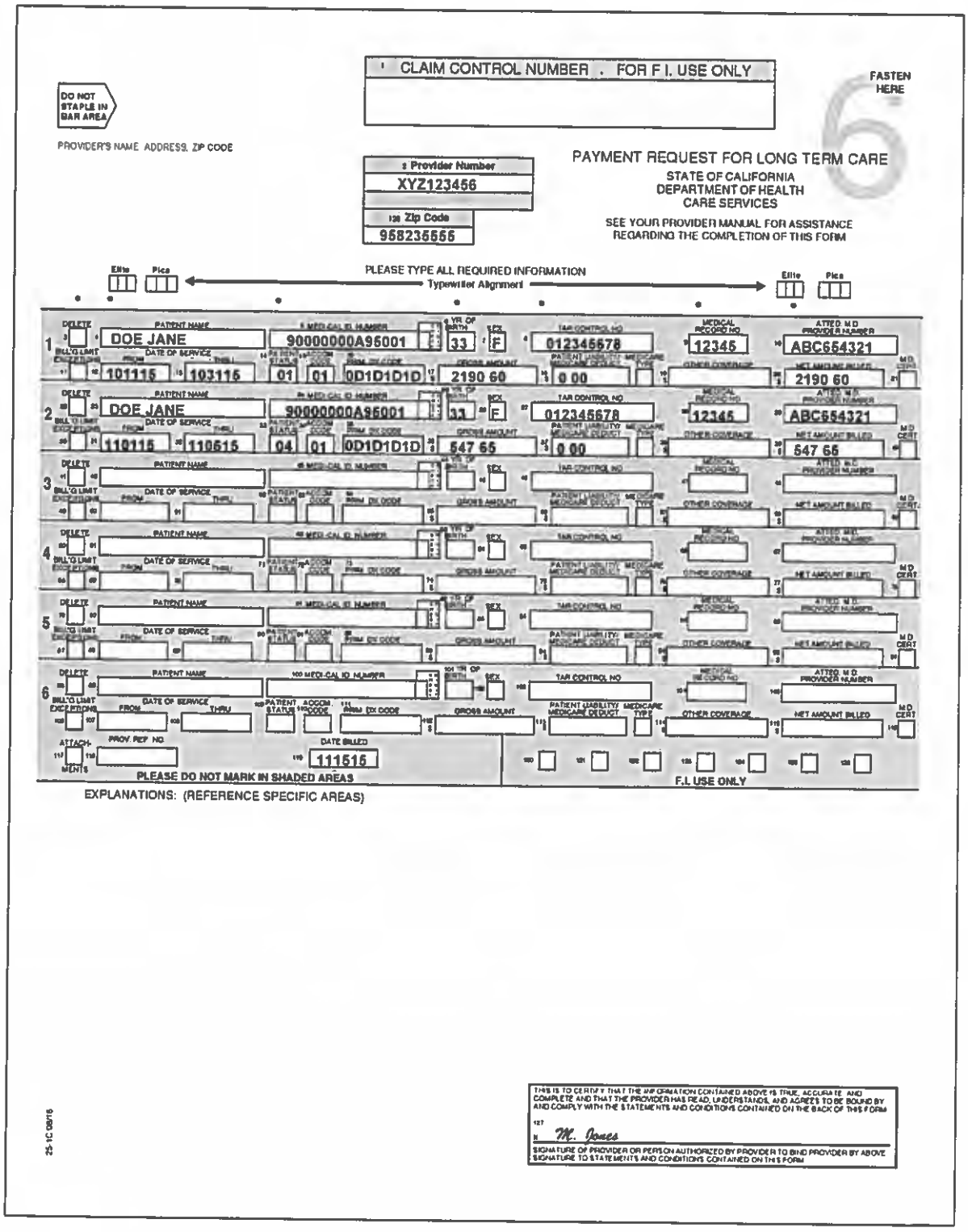

Figure 5. Discharge to Home.

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Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*ADULT SUBACUTE PROGRAM*

To expedite your request for authorization/reauthorization of SUBACUTE CARE SERVICES, it is **essential** that you complete the information below. Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4. Diagnosis			
5. Medi-Cal Identification Number	6. Current level of care	Date of admission	
7. Name of current provider of above level of care			
Address (number, street)	City	State	ZIP Code
8. Family name		Telephone ( )	
Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse; **and**, please summarize care requirements each shift: _____ ☐ ☐

b. **One** of the following (1), (2), (3):

(1) Patient has a tracheostomy and requires mechanical ventilation at least 50 percent of the day. ☐ ☐

(2) Patient has a tracheostomy and requires suctioning and room air mist or oxygen **and** one of the treatment procedures listed below (check all that apply). ☐ ☐

- ☐ (a) Total Parenteral Nutrition (TPN)
- ☐ (b) Inpatient physical, occupational, and/or speech therapy at least two hours per day, five days per week.
- ☐ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____
- ☐ (d) Inhalation/respiratory therapy treatments at least 4 times per 24-hour period (not self administered by resident).
- ☐ (e) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
  Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____
- ☐ (f) Wound debridement, packing, and medicated irrigation with/without whirlpool therapy.
  Please explain: _____

(3) Administration of any three of the treatment procedures in b (2) (a) through (f) above. Please check all that apply. ☐ ☐

c. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

d. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

e. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

10. Authorized signature	11. Date

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to the local Medi-Cal field office when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the local Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, federal regulations require that the provider continue to complete the MDS and place in the resident's charts. To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification Number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** per Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

a–b. (4): Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

c. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

d. **Reauthorizations:** Complete this only if this is a ***reauthorization*** for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

e. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*PEDIATRIC SUBACUTE PROGRAM*

❒ Initial ❒ Reauthorization ❒ Transfer

Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary	2. Birthdate	3. Age

4.Primary Diagnosis (and any secondary diagnoses pertinent to the level of care)

5. Medi-Cal Identification Number	6. Current level of care	Date of admission

7. Name of current provider of above level of care

Address (number, street)	City	State	ZIP Code

8. Family name	Telephone ( )

Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for PEDIATRIC SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse and is under 21 years of age; and ❒ ❒

b. One of the following (1), (2), (3), (4), or (5):

(1) Patient has a tracheostomy and requires mechanical ventilation at least six hours per day. ..... ❒ ❒

(2) Patient has a tracheostomy and requires suctioning at least every six hours and room air mist or oxygen; **and** one of the treatment procedures listed below (check all that apply). ❒ ❒

❒ (a) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____

_____

❒ (b) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.

❒ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____

❒ (d) Other daily medical technologies required continuously which, in the opinion of the attending physician and the Medi-Cal consultant, require the services of a professional nurse.
Please summarize care requirements each shift: _____

_____

❒ (e) Dependence on biphasic positive airway pressure at least six hours a day, including assessment or intervention every three hours, where the patient lacks either the cognitive or physical ability to protect their airway.

(3) Dependence on total parenteral nutrition (TPN) or other intravenous nutritional support; **and** one of the treatment procedures listed above in (2) (a) through (e); including (f) below (check all that apply). ❒ ❒

❒ (f) Intermittent suctioning (nontracheostomy) at least every eight hours, **and** room air mist or oxygen.

(4) Dependence on skilled nursing care in the administration of any three of the treatment procedures in a (2) (a) through (e), including (3) (f) listed above. Please check all that apply. ❒ ❒

(5) Dependence on biphasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures specified in a (2) (a) through (e), including (3) (f) above. ❒ ❒

b. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

_____

c. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

d. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

_____

10. Authorized signature	11. Date

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—PEDIATRIC SUBACUTE PROGRAM

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to Medi-Cal TAR Processing Center when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, Federal regulations require that the provider continue to complete the MDS and place in the resident's charts.

Please indicate in one of the boxes under the title if this is an initial TAR for subacute care, a reauthorization for subacute care, or the patient is being transferred from another facility or home.

To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** Welfare & Institutions Code 14132.25; Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

   a. (1) – (5) : Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

   b. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

   c. **Reauthorizations:** Complete this only if this is a *reauthorization* for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

   d. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

Policy ~~#:~~:	MA.6104
Title:	**Opioid Medication Utilization Management**
Department:	Medical ~~Affairs~~Management
Section:	Pharmacy Management
CEO Approval:	~~Michael Schrader~~ _____
Effective Date:	01/01/~~06~~2006
~~Last Review Date:~~	~~11/01/17~~
~~Last~~ Revised Date:	~~11/01/17~~TBD
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the process by which CalOptima identifies and minimizes potential Opioid Medication Overutilization among OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima is responsible for maintaining reasonable and appropriate drug Utilization Management programs that assist in preventing prescribed Medication Overutilization, and to reduce Fraud, Waste, and Abuse in the Part D Drug program.

B. CalOptima's Opioid Medication Overutilization programs shall comply with existing Coverage Determination, Appeal, and Grievance rules, as set forth at Title 42, Code of Federal Regulations~~,~~ ~~Section~~ (CFR), Part 423 Subpart M, and ~~Chapter 18 of the Medicare Prescription Drug Benefit Manual~~Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

C. CalOptima shall ensure its Drug Management Program complies with applicable statutory and regulatory requirements, including 42 CFR § 423.153(f), and applicable guidance issued by the Centers for Medicare & Medicaid Services (CMS).

~~C.~~D. CalOptima shall utilize claim reporting methodology and drug utilization review (DUR) to identify potential Opioid Medication Overutilizers based on drug claims data through clinical thresholds and prescription patterns approved by the Pharmacy & Therapeutics (P&T) Committee. This methodology excludes, as early as possible, those Members who have legitimate clinical diagnoses that may warrant high Opioid use such as cancer patients, or others who need Palliative Care.

~~D.~~E. An edit pursuant to CalOptima's Opioid Medication Overutilization programs may override a Member's previously approved Coverage Determination Exception request, if the review conducted resulted in a determination that the previously approved dose is not Medically Necessary, appropriate, or safe for the Member.

~~E.~~F. If a Member, prescriber, and/or Pharmacy is involved in suspected fraudulent activity, CalOptima shall make referrals to the appropriate agencies, in accordance with the policy set forth in Chapter 9 of the Medicare Prescription Drug Benefit Manual and CalOptima Policy MA.9107: Fraud, Waste, and Abuse Detection.

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~~F.~~G. CalOptima shall train customer service representatives (CSRs), staff handling Coverage Determinations, and Opioid case management staff, as appropriate, to ensure they are aware of each other's role in CalOptima's Opioid Medication Overutilization program.

~~G. Opioid Medication Overutilization program communication materials and letters need not be approved by the Centers for Medicare & Medicaid Services (CMS), as they do not constitute marketing letters, but rather are ad hoc Member communications.~~

H. CalOptima shall enter information into the Medicare Advantage and Prescription Drug System (MARx) in accordance with guidelines specified by CMS.

I. CalOptima shall ensure that all drug Utilization Management techniques are medically appropriate, and that Members are given appropriate access to Medically Necessary drugs in a timely manner, as set forth in CalOptima Policy MA.6101: Coverage ~~Determination~~Determinations.

III. PROCEDURE

A. Point-of-Sale (POS) Pharmacy DUR Edits

1. CalOptima shall implement Opioid morphine milligram equivalent ~~dose (MED~~(MME) cumulative dosing POS Pharmacy edits for OneCare and OneCare Connect such that:

   a. Pharmacy claims for Opioid class medications which exceed a cumulative ~~MED~~MME threshold of ninety (90) milligrams (mg) with a prescriber count of at least two (2) prescribers will trigger a soft rejection~~. These soft rejections~~ for Opioid care coordination that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes~~.~~ indicating that the prescriber of the prescription triggering the edit and any other prescriber(s) the pharmacist deems clinically appropriate have been consulted.

      i. The pharmacist may only use the appropriate override code after completing the consultation with the prescriber(s) that includes the prescribers' confirmed intent and documenting the discussion.

      ii. CalOptima's Pharmacy Benefits Manager may audit the pharmacies' documentation of the care coordination activities described in Section III.A.1.a.i of this policy.

   b. Pharmacy claims for Opioid class medications which exceed a cumulative ~~MED~~MME threshold of ~~four~~two hundred (~~400~~200) mg will trigger a hard rejection. Hard rejections may only be overridden by a favorable Coverage Determination decision made by CalOptima, as set forth in CalOptima Policy MA.6101: Coverage ~~Determination~~Determinations.

   c. Members ~~diagnosed~~residing in a long-term care facility, in hospice care, receiving palliative or end-of-life care, with sickle cell disease, or being treated for active cancer~~ and Hospice beneficiaries~~-related pain are exempt from these POS edits.

2. CalOptima shall implement POS ~~pharmacy~~Pharmacy edits such that ~~pharmacy~~Pharmacy claims for Opioid class medications which are attempted to be filled when there is a fill for buprenorphine-containing products within the previous thirty (30) calendar days will trigger a

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soft rejection~~. These soft rejections~~ that may be overridden at the ~~pharmacy~~Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

3. CalOptima shall implement a hard safety edit to limit initial Opioid prescription fills to no more than a seven (7)-day supply.

   a. New starts will be determined with a one hundred twenty (120) day lookback to determine ongoing drug therapy.

   b. Buprenorphine products are excluded from this edit.

   c. Members residing in a long-term care facility, in hospice care, or receiving palliative or end-of-life care, with sickle cell disease, or being treated for active cancer-related pain are exempt from this POS edit.

4. CalOptima shall implement a concurrent Opioid and Benzodiazepine soft POS safety edit that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

5. CalOptima shall implement a soft POS edit for duplicative long-acting Opioid therapy (excluding buprenorphine) with a prescriber count of at least two (2) prescribers that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

B. Retrospective Identification of Opioid Medication Overutilization and Drug Management Program

1. On a monthly basis, CalOptima's Pharmacy Management Department shall ~~generate~~review medication profiles to identify Opioid Medication Overutilization.

   a. Clinical case management will be performed by CalOptima clinical pharmacists. Staff must have a current and unrestricted pharmacist license.

2. Member risk definitions

   a. Clinical guidelines and CMS Overutilization Monitoring System (OMS) Criteria will be used to identify Potential At-Risk Members based on opioid use.

   b. At-Risk Members are identified from the Potential At-Risk Member population based on information obtained during case management and are subject to coverage limitations for Frequently Abused Drugs.

~~2.~~3. CalOptima's Pharmacy Management Department shall identify ~~cases of Opioid Medication Overutilization~~ Potential At-Risk Members through the following OMS criteria:

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

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

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

ii. Filled prescriptions written by ~~six (6~~five (5) or more Opioid prescribers, regardless of the number of Opioid dispensing pharmacies.

~~3.~~4. Members excluded from Opioid Medication Overutilization reports used to identify Potential At-Risk Members shall include:

~~a. Members diagnosed with cancer;~~

~~b. Hospice beneficiaries; and~~

a. ~~Identified~~ Members ~~who require high doses~~ being treated for active cancer-related pain;

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

c. Members residing in a ~~case-by-case basis~~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.

5. For Potential At-Risk Members, the Pharmacy Management Department shall also identify concurrent use of non-opioid Frequently Abused Drugs.

~~4.~~6. CalOptima shall include Potential At-Risk Members in its Medication Therapy Management program.

~~5.~~7. The Pharmacy Management Department shall evaluate data and determine an appropriate intervention strategy based on criteria developed by CMS, the P&T Committee, and the unique characteristics of the specific Opioid Medication Overutilization issue. Intervention strategies may include, but are not limited to:

a. Written notification to a Potential At-Risk Member's relevant Opioid prescriber(s) regarding ~~Medication~~ Overutilization of Frequently Abused Drugs by the Potential At-Risk Member with recommendations to optimize the medication regimen;

b. Case-specific direct prescriber contact by the Pharmacy Management Department; or

c. Referral of the prescriber to CalOptima's Quality Improvement Department due to non-responsiveness.

~~6.~~8. For Potential At-Risk Members ~~who are further evaluated for Opioid Medication Overutilization~~, CalOptima OneCare and OneCare Connect shall maintain case files, and shall furnish these case files to CMS when a complaint is made. The case files, at minimum, shall ~~minimally~~ consist of the following contents:

a. The clinical threshold and/or prescription pattern triggering the review;

b. The ~~Member~~Potential At-Risk Member's medication history;

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c. Documentation of written communication with the prescriber(s~~)~~), Potential At-Risk Member, and ~~Member;~~, if applicable, Pharmacy(ies);

d. Documentation of verbal communication with the prescriber(s~~)~~), Potential At-Risk Member, and ~~Member;~~if applicable, Pharmacy(ies);

e. Documentation and description of the results of communication with the prescriber(s~~)~~), Potential At-Risk Member, and ~~Member;~~, if applicable, Pharmacy(ies); and

f. Documentation and description of actions taken by CalOptima, such as beneficiary-level Opioid POS claim edits or Quality Improvement (QI) referrals for prescribers.

~~7.~~9. CalOptima shall determine that a Potential At-Risk Member is an At-Risk Member and implement a ~~Member-level Opioid POS claim edit~~one-year coverage limitation on that Member's access to Frequently Abused Drugs when the following conditions are met:

a. Reasonable efforts have been made to contact the prescriber(s~~) and Member,~~), such that:

i. At least one (1) written inquiry to the prescriber(s) has been made;

ii. At least three (3) attempts to reach the prescriber(s) have been made by telephone; and

iii. At least ten (10) business days has been allotted for the prescriber(s) ~~and Member~~ to reply.

b. Clinician-to-clinician communication includes information about the existence of multiple prescribers and the Potential At-Risk Member's total Opioid utilization, and elicits ~~the~~ information ~~necessary to identify~~about any ~~complicating~~ factors in the Potential At-Risk Member's treatment that are relevant to an At-Risk determination, including whether the prescribed medication is appropriate for the ~~case management effort~~Member's medical conditions or the Member is an exempted beneficiary, as defined in 42 CFR § 423.100.

c. A consensus is reached by the prescriber(s) that there is an Opioid Medication Overutilization concern and to implement a ~~Member-level opioid POS claim edit~~coverage limitation, or the prescriber(s) is unresponsive or unwilling to manage the Potential At-Risk Member's Opioid Medication Overutilization. Agreement is obtained from at least one (1) prescriber of the Potential At-Risk Member's Frequently Abused Drugs (FADs) that a coverage limitation is appropriate, except:

i. A prescriber agreement is not required for a Pharmacy Lock-in.

ii. If a prescriber does not respond after three (3) attempts by the sponsor to contact them within ten (10) business days, then CalOptima has demonstrated that the prescriber is not responsive and may proceed with a Member-specific POS edit.

iii. A Prescriber Lock-in may not be implemented if no prescriber was responsive.

d. Written notices have been provided to the Member:

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i. Initial Notice. Written notice of ~~the decision~~Potential At-Risk identification and the proposed coverage limitation is issued to the prescriber(s) and Potential At-Risk Member at least thirty (30) calendar days in advance of implementing a ~~Member-level Opioid POS claim edit.~~coverage limitation. The notice shall comply with the applicable requirements of 42 CFR § 153(f)(5), and must include, if applicable, limitation on the availability of the special enrollment period described in 42 CFR § 423.38. CalOptima shall use the Initial Notice Letter, set forth in Attachment A, to provide such notice.

ii. Second Notice. Written notice of At-Risk determination and implementation of coverage limitation is issued to the Member, prescriber(s), and Pharmacy(ies), if applicable, for Pharmacy Lock-in, with effective and end dates, upon implementation, and no later than sixty (60) calendar days after the date of Initial Notice of the proposed coverage limitation. The notice shall comply with the applicable requirements of 42 CFR § 423.153(f)(6), and must include, if applicable, any limitation on the availability of the special enrollment period described in 42 CFR § 423.38. CalOptima shall use the Second Notice Letter, set forth in Attachment B, to provide such notice.

10. If, after providing the Initial Notice under Section III.B.9.d.ii of this policy, case management findings determine that Potential At-Risk Member is not an At-Risk Member and no coverage limitation is warranted, the Member and prescriber(s) will be notified after thirty (30) calendar days from the date of the Initial Notice but no later than sixty (60) calendar days from the date of the Initial Notice. The notice shall comply with the applicable requirements of 42 CFR § 423.153(f)(7), and must include, if applicable, that the limitation on the special enrollment period no longer applies. CalOptima shall use the Alternate Second Notice Letter, set forth in Attachment C, to provide such notice.

11. If CalOptima implements a POS claim edit per Section 423.153(f)(3)(i), CalOptima must not cover FADs for the Member in excess of the edit, unless the edit is terminated or revised based on a subsequent determination (including a successful Appeal).

12. If CalOptima implements a Prescriber Lock-in or a Pharmacy Lock-in for a Member, CalOptima must cover FADs for the Member only when they are obtained from the selected Pharmacy(ies) or prescriber(s) or both, as applicable:

a. In accordance with all other coverage requirements of the prescription drug benefit plan, unless the limit is terminated or revised based on a subsequent determination (including a successful Appeal); and

b. Except as necessary to provide reasonable access in accordance with Section 423.153(f)(12).

c. The At-Risk Member's Pharmacy/prescriber preferences (as long as in-network) must be accepted unless CalOptima determines that the selection would contribute to drug abuse or diversion.

i. If a Member submits preferences for prescribers and/or pharmacies, CalOptima will inform the Member of the selection or change in selection in:

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a) The Second Notice; or

b) If the Second Notice is not feasible due to the timing of the Member's submission, in a subsequent written notice, issued no later than fourteen (14) days after receipt of the submission.

ii. In the case of a group practice, all prescribers of the group practice must be treated as one prescriber.

iii. In the case of a Pharmacy that has multiple locations that share real-time electronic data, all such locations of the Pharmacy must collectively be treated as one Pharmacy.

iv. CalOptima must notify the prescriber or Pharmacy, as applicable, that the Member has been identified for inclusion in the DMP and that the prescriber or Pharmacy or both is (are) being selected as the Member's designated prescriber or Pharmacy or both for FADs. For prescribers, this notification occurs during case management or when the prescriber provides agreement that the specific limitation is appropriate for the Member. CalOptima must then receive and retain in case files confirmation from the prescriber(s) or Pharmacy(ies) or both, as applicable, that the selection is accepted before conveying this information to the Member.

v. If CalOptima determines that the Member's selection would contribute to drug abuse or diversion, written notice of change of selected Pharmacy or prescriber for lock-in with rationale must be issued to the At-Risk Member at least thirty (30) calendar days before changing the selections.

13. CalOptima may extend a coverage limitation regarding an At-Risk Member for one (1) additional year after the first year limitation subject to the following requirements:

a. CalOptima determines at the end of the first year of limitation that there is a clinical basis to extend the limitation;

b. CalOptima obtains the agreement of a prescriber of FADs for the At-Risk Member that the limitation should be extended, except that:

i. A prescriber agreement is not required to extend a Pharmacy Lock-in.

ii. If no prescriber was responsive after three (3) attempts by CalOptima to contact the prescribers within the (10) business days, a prescriber's agreement is not necessary to extend a beneficiary-specific POS edit.

iii. A Prescriber Lock-in may not be extended if no prescriber was responsive.

c. CalOptima provides another written Second Notice to the At-Risk Member in compliance with 42 CFR § 423.153(f)(6).

14. If CalOptima subsequently intends to make a change to the terms of an ongoing limitation(s), including the intention to impose an additional limitation on the At-Risk Member, CalOptima

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must comply with Section 423.153(f)(3) and the applicable requirements for Member notices in Section 423.153(f)(5) to (8).

15. The identification of an At-Risk Member must terminate as of the earlier of the following:

a. The date the Member demonstrates through subsequent determination (including but not limited to a successful Appeal) that the Member is no longer likely to be At-Risk in the absence of the limitation; or

b. The date that is the end of:

i. The one (1) year period calculated from the effective date of the limitation (as specified in the Second Notice), unless the limitation was extended; or

ii. The two (2) year period calculated from the effective date of the limitation (as specified in the Second Notice), if the limitation was extended.

16. CalOptima will address Members who meet the definition of At-Risk or Potential At-Risk Members and enroll or disenroll from the plan.

a. CalOptima shall monitor reports and notifications of incoming enrollees who meet the definition of an At-Risk Member or a Potential At-Risk Member.

b. CalOptima shall respond to requests from other sponsors for information about At-Risk and Potential At-Risk Members who recently disenrolled from CalOptima's prescription drug benefit plan.

c. If a Member is identified as a Potential At-Risk Member or an At-Risk Member by his or her most recent prior Part D plan and such identification has not been terminated, CalOptima is not required to engage in case management, so long as CalOptima obtains case management information from the previous sponsor and such information is still clinically adequate and up to date.

d. CalOptima may forego providing the Initial Notice and may immediately provide a Second Notice to an At-Risk Member if CalOptima is the gaining plan sponsor and is implementing either:

i. A beneficiary-specific POS claim edit, if the edit is the same one that was implemented in the immediately prior plan.

ii. A limitation on access to coverage, if the limitation would require the Member to obtain FADs from the same location of Pharmacy and/or the same prescriber, as applicable, that was selected under the immediately prior plan.

~~8.~~17. CalOptima shall enter information about all Member-level Opioid POS ~~claim~~claims edits or coverage limitations into the Medicare Advantage and Prescription Drug System (MARx~~):~~) for affected At-Risk Members:

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a. Within seven (7) ~~business~~calendar days of the date on the Initial Notice of Potential At-Risk status; and

~~a.~~b. Within seven (7) calendar days of the date on the At-Risk Member's ~~written advance notice~~Second Notice when a decision is made to implement a Member-level Opioid POS claim edit or limitation on access to coverage for FADs; and

~~b.~~c. Within seven (7) ~~business~~calendar days of the event of implementation, termination, and modification of Member-level Opioid POS claim edits or limitation on access to coverage for FADs.

~~9.~~18. CalOptima's ~~Opioid Medication Overutilization program~~Drug Management Program communication materials may include, but are not limited to:

a. ~~Drug Overutilization~~ Initial ~~Member Inquiry~~Notice Letter~~:~~ (Attachment A): Initial ~~notice~~Notice to the Member that the Member has been identified as a Potential At-Risk Member, the Member's high Opioid use is being reviewed as a health care safety issue, and coverage limitation has been proposed.

b. ~~Drug Overutilization~~ Initial Prescriber Inquiry Letter: Written inquiry to a prescriber of the Opioid medication(s) about the appropriateness, Medical Necessity, and safety of the identified high dosage.

c. ~~Drug Overutilization~~Second Notice ~~of Member~~ Letter~~:~~ (Attachment B): A notice that would be issued to the At-Risk Member and the prescriber(s) informing ~~them of the results of Case Management, and that includes information~~ about Appeal rights that:

~~i.~~ The ~~Opioid use was determined to be appropriate and Medically Necessary, and~~ Member is ~~therefore covered; or~~

i. ~~A Member-level Opioid POS claim edit~~considered an At-Risk Member and a coverage limitation shall be implemented ~~that~~on Opioid and/or Benzodiazepine medications, which may include:

a) Member-level FAD POS claim edit, which allows coverage of none, or only a certain amount of~~, Opioid~~ FAD prescriptions~~.~~; and/or

b) Pharmacy Lock-in; and/or

c) Prescriber Lock-in.

d. Alternate Second Notice Letter (Attachment C): A notice that would be issued to the Potential At-Risk Member and the prescriber(s) informing them that the Member is not considered an At-Risk Member and no coverage limitation will be implemented.

C. Reporting

1. CalOptima ~~shall provide CMS with~~ must disclose any data and information ~~concerning~~to CMS and other Part D sponsors that CMS deems necessary to oversee the ~~procedures and the performance of its Opioid Medication Overutilization management program,~~Part D DMP at a

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time, and in ~~accordance with guidelines~~a form and manner specified by CMS ~~via the Medicare Part D Overutilization Monitoring System (OMS) no less often~~, including:

a. Provide information to CMS within 30 days of receiving CMS report about a Potential At-Risk Member.

b. Provide information to CMS about any Potential At-Risk Member that CalOptima identifies within 30 days from the date of the most recent CMS report identifying Potential At-Risk Members.

c. Transfer case management information using the DMP Sponsor Information Transfer Memorandum (Attachment E) upon request of a gaining sponsor as soon as possible but not later than ~~quarterly~~two (2) weeks from the gaining sponsor's request when:

i. An At-Risk or Potential At-Risk Member disenrolls from CalOptima's plan and enrolls in another prescription drug plain offered by the gaining sponsor; and

~~i.~~ii. The edit or limitation that CalOptima implemented for the beneficiary had not terminated before disenrollment.

2. CalOptima Pharmacy Management Department shall report information concerning the Opioid Medication Overutilization management program internally to the P&T Committee.

~~IV. ATTACHMENTS~~

~~Not Applicable~~

~~V. REFERENCES~~

3. CalOptima is responsible for reporting certain data elements relating to Members with either a soft and/or hard formulary-level cumulative MME POS edit, as described in the annual Medicare Part D Reporting Requirements document.

IV. ATTACHMENT(S)

A. Initial Notice Letter – Notice of Intent to Limit Access to Certain Part D Drugs
B. Second Notice Letter – Your Access to Certain Part D Drugs is Limited
C. Alternate Second Notice Letter
D. CMS Form Instructions for Drug Management Program Notices
E. Drug Management Program Sponsor Information Transfer Memorandum

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Policy MA.6101: Coverage Determination
C. CalOptima Policy MA.9107: Fraud, Waste, and Abuse Detection
D. CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect
E. Medicare Prescription Drug Benefit Manual, Chapter 9: Revised January 11, 2013
~~F. Medicare Prescription Drug Benefit Manual, Chapter 18: Revised May 12, 2014~~
F. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance: February 2019

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G. Improving Drug Utilization Review Controls in Part D, CY 2013 Final Call Letter: April 2, 2012
H. Improving Drug Utilization Review Controls in Part D, CY 2017 Final Call Letter: April 4, 2016
I. Improving Drug Utilization Review Controls in Part D, CY 2018 Final Call Letter: April 3, 2017
J. Improving Drug Utilization Review Controls in Part D, CY 2019 Final Call Letter: April 2, 2018
K. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019
L. Additional Guidance on Contract Year 2019 Formulary-Level Opioid Point-of-Sale Safety Edits, CMS Letter: October 23, 2018.
M. Part D Drug Management Program Policy Guidance, CMS Letter: November 20, 2018
~~J.~~N. Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D. September 6, 2012~~.~~
~~K.~~O. Title 42, Code of Federal Regulations (CFR), Part 423 Subpart M
~~L.~~P. Title 42, Code of Federal Regulations (CFR), §§ 423.100, 423.153(b)(1)(2) and (3) and (f)

VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

None to Date

VII. BOARD APPROVAL(S)

None to Date

~~VII. BOARD APPROVALS~~

~~None to Date~~

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/2006	MA.6104	Medication Utilization Management	OneCare
Revised	03/01/2007	MA.6104	Medication Utilization Management	OneCare
Revised	10/01/2012	MA.6104	Controlled Substance Medication Utilization Management	OneCare
Revised	06/01/2015	MA.6104	Controlled Substance Medication Utilization Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect
Revised	11/01/2017	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect
Revised	TBD	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	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.
Alternate Second Notice	Written communication to a Member if CalOptima determines that a Member is not at-risk and states that CalOptima will not limit their access to FADs under the DMP and that the limitation on the special enrollment period (SEP) no longer applies.
At-Risk Member	A Part D eligible individual: (1) who is identified using clinical guidelines, who is not an exempted beneficiary, and is determined to be at-risk for misuse or abuse of frequently abused drugs such as Opioid medications under CalOptima's drug management program; or (2) with respect to whom CalOptima receives a notice upon the Member's enrollment that the Member was identified as an at-risk beneficiary under the Part D plan in which the Member was most recently enrolled and such identification had not been terminated upon disenrollment.
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Coverage Determination	Any decision, or failure to decide in a timely manner, made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.
Drug Management Program (DMP)	Program to address Members at-risk for misuse or abuse of FADs.
Exempted Beneficiaries	A Member who: (1) has elected to receive hospice care or is receiving palliative or end-of-life care; (2) is a resident of a long-term care facility, of a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single Pharmacy; or (3) is being treated for active cancer-related pain. Members with sickle-cell disease are also exempt from Opioid POS edits but not from the Drug Management Program.

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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).
Frequently Abused Drugs (FADs)	A controlled substance under the Federal Controlled Substances Act that the Secretary determines is frequently abused or diverted, taking into account all of the following factors: (1) The drug's schedule designation by the Drug Enforcement Administration; (2) Government or professional guidelines that address that a drug is frequently abused or misused. (3) An analysis of Medicare or other drug utilization or scientific data. These drugs are determined by CMS annually.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Initial Notice	Written communication to a Potential At-Risk Member that notifies them that they have been identified as potentially at-risk for misuse or abuse of FADs, and that CalOptima intends to limit their access to FADs under its DMP, describes the specific coverage limitation(s) and decision timeframe, explains how the Member or their prescriber can provide additional information if they do not agree with the intended action, explains Appeal rights, and informs the Member of the limitation on the availability of the special enrollment period (SEP).
Medically Necessary	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~~Member, or otherwise ~~medically necessary~~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.
Medication Overutilization	Any medication when used; 1. In excessive dose, including duplicate therapy; 2. For an excessive duration; 3. Without adequate monitoring; 4. Without adequate indications for its use; 5. In the presence of adverse consequences indicating a reduction in dose, or a discontinuation of the medication; or 6. Any combinations of the reasons above.
Member	An enrollee-beneficiary of a CalOptima program.

Term	Definition
Overutilization Monitoring System (OMS) Criteria	Criteria determined by CMS annually to identify Part D beneficiaries whom CMS believes are at the highest risk of adverse events or overdose due to their level of opioid use and/or obtaining them from multiple prescribers/pharmacies.
Opioid drug	For the purposes of this policy, means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such ~~addition~~addiction-forming or addiction-sustaining liability.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Part D Program	Medicare's prescription drug benefit program.
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of ~~pharmacy~~Pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy & Therapeutics (P&T) Committee	A committee, the majority of whose ~~members~~Members shall consist of individuals who are practicing physicians or practicing pharmacists (or both), that is charged with developing and reviewing a formulary. Such committee shall include at least one practicing physician and at least one (1) practicing pharmacist, each of whom is independent and free of conflict with respect to the Sponsor and at least one practicing physician and at least one practicing pharmacist who have expertise in the care of elderly or disabled persons. (See Title 42 C.F.R. § 423.120(b)(1)).
Pharmacy Lock-in	Coverage limitation which limits access to coverage for FADs to selected pharmacies
Potential At-Risk Member	A Part D eligible individual: (1) who is identified using clinical guidelines for potential overutilization of frequently abused drugs such as Opioid medications under CalOptima's Drug Management Program; or (2) with respect to whom CalOptima receives a notice upon the Member's enrollment that the Member was identified as a potential at-risk beneficiary under the Part D plan in which the Member was most recently enrolled and such identification had not been terminated upon disenrollment.
Prescriber Lock-in	Coverage limitation which limits access to coverage for FADs to drugs prescribed by selected prescribers.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.
Second Notice	Written communication to an At-Risk Member that notifies them that CalOptima has identified them as at risk for misuse or abuse of FADs and is limiting their access to FADs under the DMP, describes the specific coverage limitations, explains how the Member can submit preferences for the selected Pharmacy and/or prescriber, if applicable, explains the Member's right to redetermination, and informs them that the limitation on the special enrollment period (SEP) continues.

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Term	Definition
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	MA.6104
Title:	**Opioid Medication Utilization Management**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/2006
Revised Date:	TBD
Applicable to:	☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines the process by which CalOptima identifies and minimizes potential Opioid Medication Overutilization among OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima is responsible for maintaining reasonable and appropriate drug Utilization Management programs that assist in preventing prescribed Medication Overutilization, and to reduce Fraud, Waste, and Abuse in the Part D Drug program.

B. CalOptima's Opioid Medication Overutilization programs shall comply with existing Coverage Determination, Appeal, and Grievance rules, as set forth at Title 42, Code of Federal Regulations (CFR), Part 423 Subpart M, and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

C. CalOptima shall ensure its Drug Management Program complies with applicable statutory and regulatory requirements, including 42 CFR § 423.153(f), and applicable guidance issued by the Centers for Medicare & Medicaid Services (CMS).

D. CalOptima shall utilize claim reporting methodology and drug utilization review (DUR) to identify potential Opioid Medication Overutilizers based on drug claims data through clinical thresholds and prescription patterns approved by the Pharmacy & Therapeutics (P&T) Committee. This methodology excludes, as early as possible, those Members who have legitimate clinical diagnoses that may warrant high Opioid use such as cancer patients, or others who need Palliative Care.

E. An edit pursuant to CalOptima's Opioid Medication Overutilization programs may override a Member's previously approved Coverage Determination Exception request, if the review conducted resulted in a determination that the previously approved dose is not Medically Necessary, appropriate, or safe for the Member.

F. If a Member, prescriber, and/or Pharmacy is involved in suspected fraudulent activity, CalOptima shall make referrals to the appropriate agencies, in accordance with the policy set forth in Chapter 9 of the Medicare Prescription Drug Benefit Manual and CalOptima Policy MA.9107: Fraud, Waste, and Abuse Detection.

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G. CalOptima shall train customer service representatives (CSRs), staff handling Coverage Determinations, and Opioid case management staff, as appropriate, to ensure they are aware of each other's role in CalOptima's Opioid Medication Overutilization program.

H. CalOptima shall enter information into the Medicare Advantage and Prescription Drug System (MARx) in accordance with guidelines specified by CMS.

I. CalOptima shall ensure that all drug Utilization Management techniques are medically appropriate, and that Members are given appropriate access to Medically Necessary drugs in a timely manner, as set forth in CalOptima Policy MA.6101: Coverage Determinations.

III. PROCEDURE

A. Point-of-Sale (POS) Pharmacy DUR Edits

1. CalOptima shall implement Opioid morphine milligram equivalent (MME) cumulative dosing POS Pharmacy edits for OneCare and OneCare Connect such that:

   a. Pharmacy claims for Opioid class medications which exceed a cumulative MME threshold of ninety (90) milligrams (mg) with a prescriber count of at least two (2) prescribers will trigger a soft rejection for Opioid care coordination that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes indicating that the prescriber of the prescription triggering the edit and any other prescriber(s) the pharmacist deems clinically appropriate have been consulted.

      i. The pharmacist may only use the appropriate override code after completing the consultation with the prescriber(s) that includes the prescribers' confirmed intent and documenting the discussion.

      ii. CalOptima's Pharmacy Benefits Manager may audit the pharmacies' documentation of the care coordination activities described in Section III.A.1.a.i of this policy.

   b. Pharmacy claims for Opioid class medications which exceed a cumulative MME threshold of two hundred (200) mg will trigger a hard rejection. Hard rejections may only be overridden by a favorable Coverage Determination decision made by CalOptima, as set forth in CalOptima Policy MA.6101: Coverage Determinations.

   c. Members residing in a long-term care facility, in hospice care, receiving palliative or end-of-life care, with sickle cell disease, or being treated for active cancer-related pain are exempt from these POS edits.

2. CalOptima shall implement POS Pharmacy edits such that Pharmacy claims for Opioid class medications which are attempted to be filled when there is a fill for buprenorphine-containing products within the previous thirty (30) calendar days will trigger a soft rejection that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

3. CalOptima shall implement a hard safety edit to limit initial Opioid prescription fills to no more than a seven (7)-day supply.

   a. New starts will be determined with a one hundred twenty (120) day lookback to determine ongoing drug therapy.

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b. Buprenorphine products are excluded from this edit.

c. Members residing in a long-term care facility, in hospice care, or receiving palliative or end-of-life care, with sickle cell disease, or being treated for active cancer-related pain are exempt from this POS edit.

4. CalOptima shall implement a concurrent Opioid and Benzodiazepine soft POS safety edit that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

5. CalOptima shall implement a soft POS edit for duplicative long-acting Opioid therapy (excluding buprenorphine) with a prescriber count of at least two (2) prescribers that may be overridden at the Pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

B. Retrospective Identification of Opioid Medication Overutilization and Drug Management Program

1. On a monthly basis, CalOptima's Pharmacy Management Department shall review medication profiles to identify Opioid Medication Overutilization.

a. Clinical case management will be performed by CalOptima clinical pharmacists. Staff must have a current and unrestricted pharmacist license.

2. Member risk definitions

a. Clinical guidelines and CMS Overutilization Monitoring System (OMS) Criteria will be used to identify Potential At-Risk Members based on opioid use.

b. At-Risk Members are identified from the Potential At-Risk Member population based on information obtained during case management and are subject to coverage limitations for Frequently Abused Drugs.

3. CalOptima's Pharmacy Management Department shall identify Potential At-Risk Members through the following OMS criteria:

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 filled at three (3) or more Opioid dispensing pharmacies; or

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

4. Members excluded from Opioid Medication Overutilization reports used to identify Potential At-Risk Members shall include:

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

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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.

5. For Potential At-Risk Members, the Pharmacy Management Department shall also identify concurrent use of non-opioid Frequently Abused Drugs.

6. CalOptima shall include Potential At-Risk Members in its Medication Therapy Management program.

7. The Pharmacy Management Department shall evaluate data and determine an appropriate intervention strategy based on criteria developed by CMS, the P&T Committee, and the unique characteristics of the specific Opioid Medication Overutilization issue. Intervention strategies may include, but are not limited to:

   a. Written notification to a Potential At-Risk Member's relevant Opioid prescriber(s) regarding Overutilization of Frequently Abused Drugs by the Potential At-Risk Member with recommendations to optimize the medication regimen;

   b. Case-specific direct prescriber contact by the Pharmacy Management Department; or

   c. Referral of the prescriber to CalOptima's Quality Improvement Department due to non-responsiveness.

8. For Potential At-Risk Members, CalOptima OneCare and OneCare Connect shall maintain case files, and shall furnish these case files to CMS when a complaint is made. The case files, at minimum, shall consist of the following contents:

   a. The clinical threshold and/or prescription pattern triggering the review;

   b. The Potential At-Risk Member's medication history;

   c. Documentation of written communication with the prescriber(s), Potential At-Risk Member, and, if applicable, Pharmacy(ies);

   d. Documentation of verbal communication with the prescriber(s), Potential At-Risk Member, and if applicable, Pharmacy(ies);

   e. Documentation and description of the results of communication with the prescriber(s), Potential At-Risk Member, and, if applicable, Pharmacy(ies); and

   f. Documentation and description of actions taken by CalOptima, such as beneficiary-level Opioid POS claim edits or Quality Improvement (QI) referrals for prescribers.

9. CalOptima shall determine that a Potential At-Risk Member is an At-Risk Member and implement a one-year coverage limitation on that Member's access to Frequently Abused Drugs when the following conditions are met:

   a. Reasonable efforts have been made to contact the prescriber(s), such that:

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i. At least one (1) written inquiry to the prescriber(s) has been made;

ii. At least three (3) attempts to reach the prescriber(s) have been made by telephone; and

iii. At least ten (10) business days has been allotted for the prescriber(s) to reply.

b. Clinician-to-clinician communication includes information about the existence of multiple prescribers and the Potential At-Risk Member's total Opioid utilization, and elicits information about any factors in the Potential At-Risk Member's treatment that are relevant to an At-Risk determination, including whether the prescribed medication is appropriate for the Member's medical conditions or the Member is an exempted beneficiary, as defined in 42 CFR § 423.100.

c. A consensus is reached by the prescriber(s) that there is an Opioid Medication Overutilization concern and to implement a coverage limitation, or the prescriber(s) is unresponsive or unwilling to manage the Potential At-Risk Member's Opioid Medication Overutilization. Agreement is obtained from at least one (1) prescriber of the Potential At-Risk Member's Frequently Abused Drugs (FADs) that a coverage limitation is appropriate, except:

i. A prescriber agreement is not required for a Pharmacy Lock-in.

ii. If a prescriber does not respond after three (3) attempts by the sponsor to contact them within ten (10) business days, then CalOptima has demonstrated that the prescriber is not responsive and may proceed with a Member-specific POS edit.

iii. A Prescriber Lock-in may not be implemented if no prescriber was responsive.

d. Written notices have been provided to the Member:

i. Initial Notice. Written notice of Potential At-Risk identification and the proposed coverage limitation is issued to the prescriber(s) and Potential At-Risk Member at least thirty (30) calendar days in advance of implementing a coverage limitation. The notice shall comply with the applicable requirements of 42 CFR § 153(f)(5), and must include, if applicable, limitation on the availability of the special enrollment period described in 42 CFR § 423.38. CalOptima shall use the Initial Notice Letter, set forth in Attachment A, to provide such notice.

ii. Second Notice. Written notice of At-Risk determination and implementation of coverage limitation is issued to the Member, prescriber(s), and Pharmacy(ies), if applicable, for Pharmacy Lock-in, with effective and end dates, upon implementation, and no later than sixty (60) calendar days after the date of Initial Notice of the proposed coverage limitation. The notice shall comply with the applicable requirements of 42 CFR § 423.153(f)(6), and must include, if applicable, any limitation on the availability of the special enrollment period described in 42 CFR § 423.38. CalOptima shall use the Second Notice Letter, set forth in Attachment B, to provide such notice.

10. If, after providing the Initial Notice under Section III.B.9.d.ii of this policy, case management findings determine that Potential At-Risk Member is not an At-Risk Member and no coverage limitation is warranted, the Member and prescriber(s) will be notified after thirty (30) calendar

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days from the date of the Initial Notice but no later than sixty (60) calendar days from the date of the Initial Notice. The notice shall comply with the applicable requirements of 42 CFR § 423.153(f)(7), and must include, if applicable, that the limitation on the special enrollment period no longer applies. CalOptima shall use the Alternate Second Notice Letter, set forth in Attachment C, to provide such notice.

11. If CalOptima implements a POS claim edit per Section 423.153(f)(3)(i), CalOptima must not cover FADs for the Member in excess of the edit, unless the edit is terminated or revised based on a subsequent determination (including a successful Appeal).

12. If CalOptima implements a Prescriber Lock-in or a Pharmacy Lock-in for a Member, CalOptima must cover FADs for the Member only when they are obtained from the selected Pharmacy(ies) or prescriber(s) or both, as applicable:

    a. In accordance with all other coverage requirements of the prescription drug benefit plan, unless the limit is terminated or revised based on a subsequent determination (including a successful Appeal); and

    b. Except as necessary to provide reasonable access in accordance with Section 423.153(f)(12).

    c. The At-Risk Member's Pharmacy/prescriber preferences (as long as in-network) must be accepted unless CalOptima determines that the selection would contribute to drug abuse or diversion.

        i. If a Member submits preferences for prescribers and/or pharmacies, CalOptima will inform the Member of the selection or change in selection in:

            a) The Second Notice; or

            b) If the Second Notice is not feasible due to the timing of the Member's submission, in a subsequent written notice, issued no later than fourteen (14) days after receipt of the submission.

        ii. In the case of a group practice, all prescribers of the group practice must be treated as one prescriber.

        iii. In the case of a Pharmacy that has multiple locations that share real-time electronic data, all such locations of the Pharmacy must collectively be treated as one Pharmacy.

        iv. CalOptima must notify the prescriber or Pharmacy, as applicable, that the Member has been identified for inclusion in the DMP and that the prescriber or Pharmacy or both is (are) being selected as the Member's designated prescriber or Pharmacy or both for FADs. For prescribers, this notification occurs during case management or when the prescriber provides agreement that the specific limitation is appropriate for the Member. CalOptima must then receive and retain in case files confirmation from the prescriber(s) or Pharmacy(ies) or both, as applicable, that the selection is accepted before conveying this information to the Member.

        v. If CalOptima determines that the Member's selection would contribute to drug abuse or diversion, written notice of change of selected Pharmacy or prescriber for

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lock-in with rationale must be issued to the At-Risk Member at least thirty (30) calendar days before changing the selections.

13. CalOptima may extend a coverage limitation regarding an At-Risk Member for one (1) additional year after the first year limitation subject to the following requirements:

    a. CalOptima determines at the end of the first year of limitation that there is a clinical basis to extend the limitation;

    b. CalOptima obtains the agreement of a prescriber of FADs for the At-Risk Member that the limitation should be extended, except that:

        i. A prescriber agreement is not required to extend a Pharmacy Lock-in.

        ii. If no prescriber was responsive after three (3) attempts by CalOptima to contact the prescribers within the (10) business days, a prescriber's agreement is not necessary to extend a beneficiary-specific POS edit.

        iii. A Prescriber Lock-in may not be extended if no prescriber was responsive.

    c. CalOptima provides another written Second Notice to the At-Risk Member in compliance with 42 CFR § 423.153(f)(6).

14. If CalOptima subsequently intends to make a change to the terms of an ongoing limitation(s), including the intention to impose an additional limitation on the At-Risk Member, CalOptima must comply with Section 423.153(f)(3) and the applicable requirements for Member notices in Section 423.153(f)(5) to (8).

15. The identification of an At-Risk Member must terminate as of the earlier of the following:

    a. The date the Member demonstrates through subsequent determination (including but not limited to a successful Appeal) that the Member is no longer likely to be At-Risk in the absence of the limitation; or

    b. The date that is the end of:

        i. The one (1) year period calculated from the effective date of the limitation (as specified in the Second Notice), unless the limitation was extended; or

        ii. The two (2) year period calculated from the effective date of the limitation (as specified in the Second Notice), if the limitation was extended.

16. CalOptima will address Members who meet the definition of At-Risk or Potential At-Risk Members and enroll or disenroll from the plan.

    a. CalOptima shall monitor reports and notifications of incoming enrollees who meet the definition of an At-Risk Member or a Potential At-Risk Member.

    b. CalOptima shall respond to requests from other sponsors for information about At-Risk and Potential At-Risk Members who recently disenrolled from CalOptima's prescription drug benefit plan.

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c. If a Member is identified as a Potential At-Risk Member or an At-Risk Member by his or her most recent prior Part D plan and such identification has not been terminated, CalOptima is not required to engage in case management, so long as CalOptima obtains case management information from the previous sponsor and such information is still clinically adequate and up to date.

d. CalOptima may forego providing the Initial Notice and may immediately provide a Second Notice to an At-Risk Member if CalOptima is the gaining plan sponsor and is implementing either:

i. A beneficiary-specific POS claim edit, if the edit is the same one that was implemented in the immediately prior plan.

ii. A limitation on access to coverage, if the limitation would require the Member to obtain FADs from the same location of Pharmacy and/or the same prescriber, as applicable, that was selected under the immediately prior plan.

17. CalOptima shall enter information about all Member-level Opioid POS claims edits or coverage limitations into the Medicare Advantage and Prescription Drug System (MARx) for affected At-Risk Members:

a. Within seven (7) calendar days of the date on the Initial Notice of Potential At-Risk status; and

b. Within seven (7) calendar days of the date on the At-Risk Member's Second Notice when a decision is made to implement a Member-level Opioid POS claim edit or limitation on access to coverage for FADs; and

c. Within seven (7) calendar days of the event of implementation, termination, and modification of Member-level Opioid POS claim edits or limitation on access to coverage for FADs.

18. CalOptima's Drug Management Program communication materials may include, but are not limited to:

a. Initial Notice Letter (Attachment A): Initial Notice to the Member that the Member has been identified as a Potential At-Risk Member, the Member's high Opioid use is being reviewed as a health care safety issue, and coverage limitation has been proposed.

b. Initial Prescriber Inquiry Letter: Written inquiry to a prescriber of the Opioid medication(s) about the appropriateness, Medical Necessity, and safety of the identified high dosage.

c. Second Notice Letter (Attachment B): A notice that would be issued to the At-Risk Member and the prescriber(s) informing about Appeal rights that:

i. The Member is considered an At-Risk Member and a coverage limitation shall be implemented on Opioid and/or Benzodiazepine medications, which may include:

a) Member-level FAD POS claim edit, which allows coverage of none, or only a certain amount of FAD prescriptions; and/or

b) Pharmacy Lock-in; and/or

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c) Prescriber Lock-in.

d. Alternate Second Notice Letter (Attachment C): A notice that would be issued to the Potential At-Risk Member and the prescriber(s) informing them that the Member is not considered an At-Risk Member and no coverage limitation will be implemented.

C. Reporting

1. CalOptima must disclose any data and information to CMS and other Part D sponsors that CMS deems necessary to oversee the Part D DMP at a time, and in a form and manner specified by CMS, including:

   a. Provide information to CMS within 30 days of receiving CMS report about a Potential At-Risk Member.

   b. Provide information to CMS about any Potential At-Risk Member that CalOptima identifies within 30 days from the date of the most recent CMS report identifying Potential At-Risk Members.

   c. Transfer case management information using the DMP Sponsor Information Transfer Memorandum (Attachment E) upon request of a gaining sponsor as soon as possible but not later than two (2) weeks from the gaining sponsor's request when:

      i. An At-Risk or Potential At-Risk Member disenrolls from CalOptima's plan and enrolls in another prescription drug plain offered by the gaining sponsor; and

      ii. The edit or limitation that CalOptima implemented for the beneficiary had not terminated before disenrollment.

2. CalOptima Pharmacy Management Department shall report information concerning the Opioid Medication Overutilization management program internally to the P&T Committee.

3. CalOptima is responsible for reporting certain data elements relating to Members with either a soft and/or hard formulary-level cumulative MME POS edit, as described in the annual Medicare Part D Reporting Requirements document.

IV. ATTACHMENT(S)

A. Initial Notice Letter – Notice of Intent to Limit Access to Certain Part D Drugs
B. Second Notice Letter – Your Access to Certain Part D Drugs is Limited
C. Alternate Second Notice Letter
D. CMS Form Instructions for Drug Management Program Notices
E. Drug Management Program Sponsor Information Transfer Memorandum

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Policy MA.6101: Coverage Determination
C. CalOptima Policy MA.9107: Fraud, Waste, and Abuse Detection
D. CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect
E. Medicare Prescription Drug Benefit Manual, Chapter 9: Revised January 11, 2013

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F. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance: February 2019
G. Improving Drug Utilization Review Controls in Part D, CY 2013 Final Call Letter: April 2, 2012
H. Improving Drug Utilization Review Controls in Part D, CY 2017 Final Call Letter: April 4, 2016
I. Improving Drug Utilization Review Controls in Part D, CY 2018 Final Call Letter: April 3, 2017
J. Improving Drug Utilization Review Controls in Part D, CY 2019 Final Call Letter: April 2, 2018
K. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019
L. Additional Guidance on Contract Year 2019 Formulary-Level Opioid Point-of-Sale Safety Edits, CMS Letter: October 23, 2018.
M. Part D Drug Management Program Policy Guidance, CMS Letter: November 20, 2018
N. Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D. September 6, 2012
O. Title 42, Code of Federal Regulations (CFR), Part 423 Subpart M
P. Title 42, Code of Federal Regulations (CFR), §§ 423.100, 423.153(b)(1)(2) and (3) and (f)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD APPROVAL(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6104	Medication Utilization Management	OneCare
Revised	03/01/2007	MA.6104	Medication Utilization Management	OneCare
Revised	10/01/2012	MA.6104	Controlled Substance Medication Utilization Management	OneCare
Revised	06/01/2015	MA.6104	Controlled Substance Medication Utilization Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect
Revised	11/01/2017	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect
Revised	TBD	MA.6104	Opioid Medication Utilization Management	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	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.
Alternate Second Notice	Written communication to a Member if CalOptima determines that a Member is not at-risk and states that CalOptima will not limit their access to FADs under the DMP and that the limitation on the special enrollment period (SEP) no longer applies.
At-Risk Member	A Part D eligible individual: (1) who is identified using clinical guidelines, who is not an exempted beneficiary, and is determined to be at-risk for misuse or abuse of frequently abused drugs such as Opioid medications under CalOptima's drug management program; or (2) with respect to whom CalOptima receives a notice upon the Member's enrollment that the Member was identified as an at-risk beneficiary under the Part D plan in which the Member was most recently enrolled and such identification had not been terminated upon disenrollment.
Appeal	Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.
Coverage Determination	Any decision, or failure to decide in a timely manner, made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.
Drug Management Program (DMP)	Program to address Members at-risk for misuse or abuse of FADs.
Exempted Beneficiaries	A Member who: (1) has elected to receive hospice care or is receiving palliative or end-of-life care; (2) is a resident of a long-term care facility, of a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single Pharmacy; or (3) is being treated for active cancer-related pain. Members with sickle-cell disease are also exempt from Opioid POS edits but not from the Drug Management Program.
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).

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Term	Definition
Frequently Abused Drugs (FADs)	A controlled substance under the Federal Controlled Substances Act that the Secretary determines is frequently abused or diverted, taking into account all of the following factors: (1) The drug's schedule designation by the Drug Enforcement Administration; (2) Government or professional guidelines that address that a drug is frequently abused or misused. (3) An analysis of Medicare or other drug utilization or scientific data. These drugs are determined by CMS annually.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action.
Initial Notice	Written communication to a Potential At-Risk Member that notifies them that they have been identified as potentially at-risk for misuse or abuse of FADs, and that CalOptima intends to limit their access to FADs under its DMP, describes the specific coverage limitation(s) and decision timeframe, explains how the Member or their prescriber can provide additional information if they do not agree with the intended action, explains Appeal rights, and informs the Member of the limitation on the availability of the special enrollment period (SEP).
Medically Necessary	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.
Medication Overutilization	Any medication when used; 1. In excessive dose, including duplicate therapy; 2. For an excessive duration; 3. Without adequate monitoring; 4. Without adequate indications for its use; 5. In the presence of adverse consequences indicating a reduction in dose, or a discontinuation of the medication; or 6. Any combinations of the reasons above.
Member	An enrollee-beneficiary of a CalOptima program.
Overutilization Monitoring System (OMS) Criteria	Criteria determined by CMS annually to identify Part D beneficiaries whom CMS believes are at the highest risk of adverse events or overdose due to their level of opioid use and/or obtaining them from multiple prescribers/pharmacies.
Opioid drug	For the purposes of this policy, means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Part D Program	Medicare's prescription drug benefit program.

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Term	Definition
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of Pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy & Therapeutics (P&T) Committee	A committee, the majority of whose Members shall consist of individuals who are practicing physicians or practicing pharmacists (or both), that is charged with developing and reviewing a formulary. Such committee shall include at least one practicing physician and at least one (1) practicing pharmacist, each of whom is independent and free of conflict with respect to the Sponsor and at least one practicing physician and at least one practicing pharmacist who have expertise in the care of elderly or disabled persons. (See Title 42 C.F.R. § 423.120(b)(1)).
Pharmacy Lock-in	Coverage limitation which limits access to coverage for FADs to selected pharmacies
Potential At-Risk Member	A Part D eligible individual: (1) who is identified using clinical guidelines for potential overutilization of frequently abused drugs such as Opioid medications under CalOptima's Drug Management Program; or (2) with respect to whom CalOptima receives a notice upon the Member's enrollment that the Member was identified as a potential at-risk beneficiary under the Part D plan in which the Member was most recently enrolled and such identification had not been terminated upon disenrollment.
Prescriber Lock-in	Coverage limitation which limits access to coverage for FADs to drugs prescribed by selected prescribers.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.
Second Notice	Written communication to an At-Risk Member that notifies them that CalOptima has identified them as at risk for misuse or abuse of FADs and is limiting their access to FADs under the DMP, describes the specific coverage limitations, explains how the Member can submit preferences for the selected Pharmacy and/or prescriber, if applicable, explains the Member's right to redetermination, and informs them that the limitation on the special enrollment period (SEP) continues.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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

This is important information about your Medicare Part D prescription drug coverage. Read this notice carefully. For help, call one of the numbers listed on the last page under "For More Information and Help with This Notice."

[Part D Plan Logo]

NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

You are getting this notice because [Plan Name] believes your use of prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] may be unsafe. We plan to place you in our drug management program to better manage your use of these medications.

[Insert the following when at least one prescriber has responded:] {*Based on our review and communications with your prescribers(s),* [insert prescriber name(s)]*, unless we receive additional information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change on* [insert date 30 days from the date of this notice]*. The section "What If I Don't Agree?" tells you how to submit this information.*}

[Insert the following when no prescriber has responded:] {*We have contacted your prescriber(s),* [insert prescriber name(s)]*, about your use of these medications but have not received a reply. Unless we receive information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change on* [insert date 30 days from the date of this notice]*. The section "What If I Don't Agree?" tells you how to submit this information.*}

What Action Do We Intend To Take?

As of [insert date 30 days from the date of this notice], we will limit your access in the following way(s):

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other doctors [MA-PDs insert if applicable: {*even if the other doctor is in our network*}]. *You can ask us to use a different prescriber by calling us or by filling out the form at the end of this notice.*}

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by calling us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts, if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally no. As of [insert date of this notice]*, you can only change plans during the year in very limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

What Is A Drug Management Program?
[Plan Name] has a drug management program to help you use prescription opioids safely. Opioids are a class of drugs that include pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep). If we determine that your use of prescription opioids is not safe, we may limit your access to them or to other medications like benzodiazepines.

What If I Don't Agree?
You have the right to give us any information you think is important to our decision about the safety of your medication use.

[Insert this language if prescriber(s) have been non-responsive:] {*If you don't think the limitation(s) described above should apply to you, you should talk to your prescriber(s) about this notice. We*

contacted your prescriber(s), [insert names of prescriber(s)]*, about your use of these medications but have not received a reply. Your prescriber(s) can also give us information about why the limitation(s) should not apply to you.*}

[Insert this language if prescriber(s) have been responsive:] {*In making our decision, we got information from your prescriber(s),* [insert names of prescriber(s)]*. If you don't think the limitation(s) described above should apply to you, please tell us why. We have shared a copy of this notice with your prescriber(s). You should also talk to them about this notice and next steps.*}

If you or your prescriber has information you would like us to consider, you can contact us at:

[insert plan phone number, fax and address]

Note: We are not allowed to limit your access under the drug management program if you have cancer, you're in hospice or get palliative or end-of-life care, or you live in a long-term care facility. If you have information you would like us to consider, please call us at the number below within the next 30 days.

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*}, or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.*}

What Happens Next?
We will review any information you send us. We will also review information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. If we decide you're at risk and limit your access to these drugs, we'll send you another notice explaining how you, your prescriber, or your representative can ask for an appeal. You will also receive a notice if we decide you're not at risk and will not limit your access to these drugs.

Note: If you change to a different Medicare drug plan, we can give your new plan information about your case and any limitations we place on your access under our drug management program. Your new plan may place you in its drug management program as well.

What Resources Are Available to Help Me Use My Medications Safely?
[MA-PDs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit]
[MMPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment, mental health and counseling services covered under the enrollee's Medicare benefit or as a supplemental benefit, as well as any coverage under the enrollee's Medicaid benefit]
[PDPs insert a statement describing plan benefits related to treatment for prescription drug abuse, including medication assisted treatment]

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can help you learn more about opioid medications and how to use them safely, including information about mental health services and other counseling services.

For More Information and Help with This Notice
For more information about the drug management program or any of the information in this notice, please contact [Plan Name] at:

Toll Free: [Insert phone number] TTY users: [Insert TTY]
[Insert call center hours of operation]
[Insert plan website]

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0964. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

[PLAN NAME] PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at [insert phone number], faxing this form to us at [insert fax number], or by sending the completed form to: [insert address].

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

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

This is important information about your Medicare Part D prescription drug coverage.
Read this notice carefully. For help, call one of the numbers listed on the last page under "For More Information and Help with This Notice."

[Part D Plan Logo]

YOUR ACCESS TO CERTAIN PART D DRUGS IS LIMITED

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

[Insert the following language UNLESS the plan is continuing an existing limitation from the enrollee's immediately prior plan:] {*On* [*insert date of initial notice*]*, we told you that we planned to limit your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *through our drug management program. After completing our review, we have determined that your use of these drugs is unsafe.*}

[If the plan is continuing an existing limitation from the enrollee's immediately prior plan, insert the following language:] {*You are getting this notice because* [Plan Name] *has determined that the limitation(s) on your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *is unsafe. Based on our review, including information obtained from your previous Medicare Part D plan, we have placed you in our drug management program.*}

What Action Have We Taken?
Effective immediately, your access is limited in the following way(s):

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other doctors [MA-PDs insert if applicable: {*even if the other doctor is in our network*}]. *You can ask us to use a different prescriber by calling us or by filling out the form at the end of this notice.*}

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by calling us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts,

if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

Why Did We Make This Decision?
[Provide specific rationale for the plan's decision that the enrollee is an at-risk beneficiary and the limit(s) placed on the enrollee's access to frequently abused drugs under the drug management program. The rationale must include any clinical criteria, Medicare coverage rule, Part D plan policy or other information on which the plan based its decision, including information obtained through case management or subsequent clinical contact with the enrollee's prescriber(s) of frequently abused drugs.

For decisions involving the continuation of a limitation under a drug management program from the enrollee's prior plan: the rationale must include an explanation, as applicable, that the plan's decision to continue the same limitation(s) as the prior plan was based in part on information obtained from the prior plan.]

[Plan Name]'s drug management program helps you use prescription opioids safely. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep).

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can help you learn more about opioid medications and how to use them safely.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally no. As of [insert date of initial notice]*, you can only change plans during the year in very limited situations, such as you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*} or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.*}

What If I Don't Agree With This Decision?
You have the right to appeal. You can appeal our decision to limit your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}], as well as any coverage determination made under a drug management program.

If you change to a new Medicare plan, we can give your new plan information about your case and the limits we have put on your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. You also have the right to appeal our sharing of this information with the new plan.

If you want to appeal, **you must request your appeal by [insert date 60 calendar days after the date of this notice].** We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at [insert toll free plan phone number] to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY [insert TTY].

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- If you ask for an expedited appeal without support from your prescriber, we will decide

if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any information you'd like us to consider. You may wish to talk with your prescriber about your appeal.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: [insert toll free phone number]

Fax: [insert fax number]

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

[Insert address]

What Happens Next?
If you appeal, we will review your case and give you a decision. If you disagree with any part of our decision, you can request an independent review of your case by a reviewer outside of our plan. If you disagree with that decision, you will have the right to another appeal. You will be notified of your appeal rights if this happens.

For More Information and Help with This Notice
For more information about the drug management program or any of the information in this notice, please contact [Plan Name] at:

Toll Free: [Insert phone number] TTY users: [Insert TTY]
[Insert call center hours of operation]
[Insert plan website]

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

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[PLAN NAME] PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at [insert phone number], faxing this form to us at [insert fax number], or by sending the completed form to: [insert address].

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

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

[Part D Plan Logo]

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

On [Insert date of initial notice], we sent you a notice that we planned to limit your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] through our drug management program.

After further review, we have decided that your access to these medications will NOT be limited under the drug management program. There are no changes to the way these medications are covered for you under our plan rules.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*As of the date of this notice, you're eligible to use the quarterly Medicare Special Enrollment period because you receive Extra Help with your prescription drug costs. You can also change plans during other limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact us at:

[Plan Name] Toll Free: [Insert phone number] TTY users: [Insert TTY]
[Insert call center hours of operation]
[Insert plan website]

If you have questions about your opioid pain medication or other prescription drugs you are taking, speak with your prescriber.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0964. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan,

call: 1-800-MEDICARE.

Form Instructions for
Drug Management Program Notices
CMS-10141

These notices must comply with all requirements at 42 CFR §423.153(f) and these instructions.

The language in these notices is not model language. These are standard forms. Part D plan sponsors may not deviate from the content provided. The notices contain italicized text in curly brackets "{ }" to be inserted when applicable to the situation. Bracketed text "[ ]" that is not italicized provides instruction on text to be inserted in the notice.

Please note that the OMB control number must be displayed in the lower left corner of the notice.

Initial Notice ("NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS")

When a Part D plan sponsor determines that an enrollee is potentially at risk for prescription drug abuse under 42 CFR §423.153(f) and intends to limit the enrollee's access to frequently abused drugs under Part D, the plan sponsor must issue this notice to the affected enrollee. Specific instructions on optional language and fillable fields can be found within the notice.

Second Notice ("YOUR ACCESS TO CERTAIN PART D DRUGS IS LIMITED")

When a Part D plan sponsor determines that an enrollee is at risk for prescription drug abuse under 42 CFR §423.153(f), the plan sponsor must issue this notice to the affected enrollee before or concurrent with implementing a limitation on the enrollee's access to frequently abused drugs under its drug management program. Specific instructions on optional language and fillable fields can be found within the notice.

Alternate Second Notice

When, after issuing the Initial Notice described above, a Part D plan sponsor determines that an enrollee is NOT at risk for prescription drug abuse under 42 CFR §423.153(f) and will not limit the enrollee's access to frequently abused drugs under its drug management program, the Part D plan sponsor must issue this notice to the enrollee. Specific instructions on optional language and fillable fields can be found within the notice.

suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

ATTACHMENT B

Sample Part D Drug Management Program Sponsor Information Transfer Memorandum

Instructions: This memorandum could be used by a former sponsor to respond to a new sponsor that has requested case management information about a potential at-risk or at-risk beneficiary who disenrolled from the former sponsor's plan. It is intended to convey information about the former sponsor's findings about the beneficiary's prior opioid and/or benzodiazepine utilization, and to provide the new sponsor with the records and actions generated by the former sponsor's review of the beneficiary under its Drug Management Program.

DATE: <Date>

TO: New Sponsor

FROM: Former Sponsor

RE: Drug Management Program Information for <Beneficiary Name>

The purpose of this memo is to highlight certain information that <Former Sponsor Plan Name> is providing in response to a request that we received on <Date> from <New Sponsor Plan Name> to transfer case management information and associated records for <Beneficiary Name> from our Drug Management Program. <New Sponsor> received notice from <Former Sponsor> on <Date, if known by Former Sponsor> through MARx that <Beneficiary Name> had an Active CARA Status when they disenrolled from <Former Sponsor Plan Name> and enrolled in <New Sponsor Plan Name> effective <Date>.

<Beneficiary Name> had the status of [*Select one as applicable*: <potential at-risk beneficiary> <at-risk beneficiary> under <Former Sponsor Plan Name's> Drug Management Program. [*Select one, as applicable:* <We notified this potential at-risk beneficiary of their status> <We implemented a coverage limitation on frequently abused drugs for this at-risk beneficiary> on <date>.

The limitation(s) that <Former Sponsor> [*Select one, as applicable:* <intended to implement> <implemented>] on <Beneficiary Name's> access to coverage for [*Select as applicable:* <opioids> <and benzodiazepines>] is:

[[*Select if applicable:* Prescriber Limitation for [*Select as applicable*: <opioids> and <benzodiazepines>.] The selected prescriber is <Prescriber Name> and their individual NPI is <NPI #>. The contact information we have for the prescriber is <FILL IN>.]]

[[*Select if applicable:* Pharmacy Limitation for [*Select as applicable:* <opioids> and <benzodiazepines>. The selected pharmacy is <Pharmacy Name> and its organizational NPI is <NPI #>. The address we have for the pharmacy is <FILL IN>>.]]

[[*Select if applicable:* Beneficiary-specific POS claim edit for [*Select as applicable:* <Only <Drug Name> <drug strength><quantity> is covered every <Number> days>.]]

More detail is included in the documents accompanying this memorandum, which contain copies of the applicable beneficiary notice(s) and of the records from the case management that was conducted under <Former Sponsor's> Drug Management Program upon which the decision to implement the coverage limitation(s) was based. Specifically, the following minimum necessary records are permitted to be transferred under applicable law and include:

[List the records that are included. Examples of records that could be included are:

a) notation whether the beneficiary met the minimum or supplemental OMS criteria;
b) copies of medical records;
c) beneficiary drug utilization history;
d) correspondence with prescribers and the beneficiary;
e) notes documenting telephone conversations; and
f) documentation of the decision arrived at through case management.

If you have any questions concerning this memorandum, please contact <Name> <Title> at <Contact Information.>

[*Insert beneficiary identifying information]*

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Approval of CalOptima's New FQHC/RHC Pay for Performance Policy and Modified Quality Improvement Policies

Contacts
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. Approve modifications to the following policies pursuant to CalOptima's annual review process:
   a. GG.1656: Quality Improvement and Utilization Management Conflicts of Interest
   b. GG.1620: Quality Improvement Committee
2. Approve CalOptima Policy GG.1660: Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Financial Incentives and Pay for Performance Payments to comply with the Department of Health Care Services (DHCS) guidance

Background/Discussion

Modifications to Existing Quality Improvement Policies and Procedures
CalOptima regularly reviews its policies to ensure they are up-to-date and aligned with federal and state health care program requirements, regulatory and contractual obligations as well as CalOptima operations.

Below are the existing Quality Improvement policies that required modifications:

- ***GG.1656: Quality Improvement and Utilization Management Conflicts of Interest [Medi-Cal, OneCare, OneCare Connect, PACE]*** describes guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statues, and regulations. CalOptima revised this policy pursuant to the CalOptima annual review process to clarify that external reviewer or expert consultant shall be required to sign a Conflict of Interest Statement and complete a Conflict of Interest Disclosure Form prior to performing any services for CalOptima. In addition, CalOptima staff revised the policy to clarify that Credentialing and Peer Review Committee (CPRC) minutes shall reflect the disclosure of Conflicts of Interest and any abstentions and exclusions from participation from voting on actions.

Back to Agenda

- ***GG.1620: Quality Improvement Committee [Medi-Cal, OneCare, OneCare Connect]*** describes CalOptima's Quality Improvement Committee (QIC) and the process by which CalOptima assures that all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for members and providers; satisfaction for members and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the National Committee for Quality Assurance (NCQA). CalOptima staff revised this policy pursuant to the CalOptima annual policy review process. Revisions include a clarification of QIC voting members and how participating members of the QIC shall complete the Committee Confidentiality Attestation and Confidentiality Statement Attendee Signature Sheet in accordance with GG.1628: Confidentiality of Quality Improvement Activities.

New Quality Analytics Policy and Procedures
As delineated in the DHCS APL 19-005: FQHCs and RHC Financial Inventive and Pay for Performance Payment Policy, FQHCs and RHCs provide covered health care services to Medi-Cal members in federally designated medically underserved rural or urban areas and are a critical part of the health care delivery system's safety net. In order to recognize outstanding performance and support ongoing improvement in the provision of quality health care to members receiving services at FQHCs and RHCs, CalOptima staff would like to implement financial incentive payments, such as risk pool payments, bonuses, or withholds; such financial incentive payments may also be referred to as Pay for Performance (P4P) payments. CalOptima's new Policy GG.1660: FQHC and RHC Financial Incentives and Pay for Performance Payments [Medi-Cal, OneCare Connect] addresses the requirements of APL 19-005.

- ***GG.1660: FQHC and RHC Financial Incentives and Pay for Performance Payments [Medi-Cal, OneCare Connect]*** outlines the guidelines CalOptima must adhere to when structuring, implementing, and executing the financial incentives and P4P payments to FQHCs and RHCs contracted with CalOptima. This policy was created to ensure compliance with the policy requirements for financial incentive payments outlined in the DHCS APL 19-005: FQHCs and RHC Financial Incentive and P4P Payment Policy. This policy also reflects that all financial incentive payments, or P4P payments, provided to FQHCs or RHCs, as permitted under federal and state law, must be designed to ensure that they are not included in the calculations of wrap-around or supplemental payments made to the FQHC or RHC by DHCS, as well as not utilize financial incentives or P4P payments to pay an FQHC or RHC an additional rate per service or visit based exclusively on utilization.

Fiscal Impact
The recommended actions to approve revisions to CalOptima Policies GG.1656 and GG.1620 and approve CalOptima Policy GG.1660 are operational in nature and do not have an anticipated financial impact beyond what is incorporated in the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Staff will return to the Board for further consideration and approval of any changes to current payment programs, or any new proposed payment programs that address financial incentives and/or P4P payments subject to GG.1660.

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Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with contractual and regulatory guidance provided by the CalOptima's regulators (e.g., DHCS, Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. GG.1656: Quality Improvement and Utilization Management Conflicts of Interest
2. Board Action March 1, 2018, Consider Approval of CalOptima Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest
3. GG.1620: Quality Improvement Committee
4. Board Action October 3, 2019, Consider Modifications to CalOptima Quality Improvement Policies and Procedures Related to Annual Policy Review
5. GG.1660: FQHC and RHC Financial Incentives and Pay for Performance Payments
6. DHCS APL 19-005: FQHCs and RHC Financial Incentive and Pay for Performance Payment Policy
7. Board Action February 7, 2019, Consider Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

/s/ Richard Sanchez *0429/2020*

Authorized Signature **Date**

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Policy ~~#:~~:	GG.1656Δ
Title:	**Quality Improvement and Utilization Management Conflicts of Interest**
Department:	Medical ~~Affairs~~Management
Section:	Quality Improvement
CEO Approval:	~~Michael Schrader~~
Effective Date:	03/01/2018
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer, or employed position in the Quality Improvement (QI) or Utilization Management (UM) Departments or otherwise carrying out quality improvement or utilization management oversight activities, including, but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities fully disclose any actual, perceived, or potential Conflicts of Interest(s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statues, and regulations.

II. POLICY

A. It is the policy of CalOptima to promote the best interests of its Members. All decisions concerning the safe care, quality of treatment, and services provided to CalOptima's Members must be made solely with the intent to meet the needs of those Members and without any actual, perceived, or potential Conflicts of Interest. Under no circumstances may a Participant place his/her own financial interests above the welfare of CalOptima's Members.

B. Participants shall conduct their affairs so as to avoid or minimize Conflicts of Interest and must appropriately disclose when Conflicts of Interest arise.

C. Participants have a continuing obligation to disclose the existence and nature of any actual, perceived, or potential Conflicts of Interest to CalOptima in accordance with this Policy.

D. The Chief Medical Officer and/or committee chairperson shall evaluate all Conflicts of Interest and determine whether a Conflict of Interest exists, with the assistance of legal counsel, as necessary. The Chief Medical Officer and/or committee chairperson will resolve all conflicts and impose safeguards, as necessary, to appropriately manage Conflicts of Interest.

E. Delegated Health Networks shall have policies and procedures consistent with this Policy in order to identify, avoid and/or manage Conflicts of Interest, as appropriate.

III. PROCEDURE

A. Conflict of Interest

Back to Agenda

1. A Conflict of Interest depends on the situation and not on the character of the individual. Conflicts of Interest may arise where a Participant and/or a Related Party or an entity directly controlled by them:

   a. Receives material compensation (e.g., gifts, grants, stipends, amenities) from any individual (and/or his employer) or entity that is the subject of a CalOptima QI or UM review;

   b. Has an ownership interest in any entity that is the subject of a CalOptima QI or UM review;

   c. Has a past or present personal relationship with the subject of a CalOptima QI or UM review; and/or

   d. Has a financial interest in any consultant that is engaged and/or contracted by CalOptima to assist it with a QI or UM review and/or investigation.

2. The following are examples of Conflicts of Interest:

   a. A Participant considers or makes decisions with respect to a credentialing or peer review matter where the provider who is the subject of the peer review matter is a direct competitor of the Participant or an individual with whom the Participant previously had a personal, employment, or financial relationship.

   b. A Participant has an ownership or financial interest in the consulting firm engaged by CalOptima to review medical records in connection with a peer review matter.

   c. A Participant receives monetary or non-monetary compensation from a pharmaceutical manufacturer whose drug is reviewed for listing on the CalOptima Formulary.

   d. A Participant holds a fiscal or management position or role at CalOptima and participates in utilization management decisions (e.g., approving, modifying, deferring, or denying requested services, establishing drug formularies, conducting drug utilization reviews).

   e. A Participant considers and makes decisions regarding the CalOptima credentialing application of a physician where the Participant was a member of a judicial review committee that ruled on a prior hospital peer review matter involving the same physician.

B. Conflict of Interest Disclosure Process

1. On an annual basis, each Participant who is involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the Participant.

2. Upon appointment and prior to serving on any QI or UM committee or subcommittee, each Participant shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form, identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the Participant.

3. If a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest prior to a committee, or subcommittee, meeting, he/she will provide written notice to the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual Conflict of Interest.

4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest during a committee, or subcommittee, meeting, he/she will immediately alert the committee, or subcommittee, chairperson that he/she may have a potential, perceived, or actual Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may answer, any questions concerning the Conflict of Interest.

5. In all other situations, whenever a Participant realizes that he/she may have a potential or actual Conflict of Interest, he/she will provide written notice to the Chief Medical Officer disclosing the potential, perceived, or actual Conflict of Interest.

6. To the extent the QI Department and/or UM Department engages an external reviewer or expert consultant for peer review or other QI or UM purposes, that ~~individual~~external reviewer or expert consultant shall be required to sign a Conflict of Interest Statement and complete a Conflict of Interest Disclosure Form prior to performing any services for CalOptima.

C. Management and Resolution of the Conflicts of Interest

1. The Chief Medical Officer or the committee chairperson will review and evaluate all written disclosures thoroughly for conflicts. For any decision involving a CalOptima employee, the Chief Medical Officer shall involve Legal Counsel before taking any action.

2. The applicable committee or subcommittee chairperson shall resolve any issue over the existence of a Conflict of Interest involving a Participant who is a committee or subcommittee member. All other Conflict of Interest issues shall be resolved by the Chief Medical ~~Director~~Officer. CalOptima shall verify that no unresolved Conflicts of Interest exist prior to retaining ~~the~~an external reviewer or expert consultant.

3. If it is determined that there is no conflict, then the Participant can continue to be involved in the matter, subject to any limitations imposed by the Chief Medical Officer or committee or subcommittee chairperson.

4. If it is determined that there is a Conflict of Interest, the Participant may be excluded from participation in the matter that gave rise to the Conflict of Interest.

5. The committee chairperson and/or Chief Medical Officer may resolve the conflict, if and when appropriate, by imposing limitations in where there is a determination that a Conflict of Interest does not prohibit the Participant's continued involvement in the matter. These limitations may include, but are not limited to, requiring that the Participant abstain from voting with regard to the matter, or prohibiting the Participant from participating in any investigation of the matter.

6. If a Participant disagrees with a committee chairperson's decision regarding a Conflict of Interest, he/she can request that the Chief Medical Officer review the Conflict of Interest.

D. Record Retention

1. The Quality Improvement and Utilization Management Departments, as applicable, shall keep copies of all Conflict of Interest Disclosure Forms and any written information disclosing a Conflict of Interest in accordance with applicable regulatory record retention requirements.

2. Credentialing and Peer Review Committee (CPRC) minutes shall reflect the disclosure of Conflicts of Interest and any abstentions and exclusions from participation from voting on actions.

E. Non-Compliance with Conflicts of Interest

1. Suspected violations of this Policy should be reported to the Chief Medical Officer. Such reports may be made confidentially.

2. The failure of a Participant to disclose a Conflict of Interest when it is known or reasonably should be known to the Participant may result in actions against the Participant, including, but not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a committee or subcommittee. The matter may also be referred to the CalOptima Office of Compliance and/or Human Resources Department for further action, as appropriate.

IV. ATTACHMENT(S)

A. Conflict of Interest Attestation
B. Conflict of Interest and Non-Discrimination Attestation (CPRC)
C. Conflict of Interest Disclosure Form

V. REFERENCE(S)

A. Cal MediConnect Quality Improvement TAG QI-001
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and DHCS for Cal MediConnect
F. Health and Safety Code §1367(g)
G. Title 42, Code of Federal Regulations (C.F.R.), §422.205
H. Title 28, California Code of Regulations, §1300.67.3

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2018	GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2018	GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

1

IX. GLOSSARY

Term	Definition
Conflict of Interest	~~A~~For purposes of this policy, a conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.
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.
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.
Member	An enrollee-beneficiary of a CalOptima program.
Participant	~~Any~~For purposes of this policy, any individual serving in an appointed, volunteer, or employed position in CalOptima QI and/or UM Departments and/or on any QI or UM committees or subcommittees. This includes, but is not limited to, those individuals making decisions in connection with member quality of care complaints and grievances, provider credentialing and re-credentialing, and/or peer review activities.
Related Party	~~The~~For purposes of this policy, the Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent.

Policy :	GG.1656Δ
Title:	**Quality Improvement and Utilization Management Conflicts of Interest**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	03/01/2018
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Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

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F. Health and Safety Code §1367(g)
G. Title 42, Code of Federal Regulations (C.F.R.), §422.205
H. Title 28, California Code of Regulations, §1300.67.3

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/01/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2018	GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2018	GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised		GG.1656Δ	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
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Related Party	For purposes of this policy, the Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent.

Conflict of Interest Attestation

[Quality Improvement Committee/Sub-Committee(s)]

I, _____, agree and attest as follows:

1. I am a member of the following CalOptima [Quality Improvement Committee/Sub-Committee(s)]: _____.

2. I understand CalOptima requires that all individuals who serve on [Quality Improvement Committee/Sub-Committee(s)] or who otherwise make decisions on quality oversight and activities ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

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4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's ~~patients~~ members must be made solely with the intent to meet the needs of those ~~patients~~ members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima's patients.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.*, abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

_____

Signature

_____

Printed Name

_____

Date

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Conflict of Interest Attestation

[Quality Improvement Committee/Sub-Committee(s)]

I, _____, agree and attest as follows:

1. I am a member of the following CalOptima [Quality Improvement Committee/Sub-Committee(s)]: _____.

2. I understand CalOptima requires that all individuals who serve on [Quality Improvement Committee/Sub-Committee(s)] or who otherwise make decisions on quality oversight and activities ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

Back to Agenda

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima's patients.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.*, abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

_____

Signature

_____

Printed Name

_____

Date

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Conflict of Interest and Non-Discrimination Attestation

Credentialing ~~and~~and ~~-~~Peer Review Committee

I, _____, agree and attest as follows:

1. I am a member of the CalOptima Credentialing ~~and~~and ~~–~~Peer Review Committee (CPRC).

2. I understand CalOptima requires that all individuals who serve on the CPRC ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima members.

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6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.,* abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

9. I acknowledge that Federal law prohibits CalOptima from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.

10. I acknowledge and understand that I may not base credentialing or re-credentialing recommendations or decisions and/or peer review recommendations or decisions on a provider's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against any CalOptima provider in making such recommendations or decisions.

_____

Signature

_____

Printed Name

_____

Date

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Conflict of Interest and Non-Discrimination Attestation

Credentialing and Peer Review Committee

I, _____, agree and attest as follows:

1. I am a member of the CalOptima Credentialing and Peer Review Committee (CPRC).

2. I understand CalOptima requires that all individuals who serve on the CPRC ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima members.

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6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.,* abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

9. I acknowledge that Federal law prohibits CalOptima from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.

10. I acknowledge and understand that I may not base credentialing or re-credentialing recommendations or decisions and/or peer review recommendations or decisions on a provider's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against any CalOptima provider in making such recommendations or decisions.

_____

Signature

_____

Printed Name

_____

Date

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CALOPTIMA CONFLICT OF INTEREST DISCLOSURE FORM

Quality Improvement and Utilization Management Departments, Committees and Subcommittees

Name: _____

Department\Organization: _____

Committee/Subcommittee: _____

Please complete the information below. The terms "Conflict of Interest" and "Related Party" as used in this Conflict of Interest Disclosure Form are defined below.

Definitions:

A. **Conflict of Interest**: A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.

B. **Related Party**: The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent**.**

Conflict of Interest Disclosures:

Please answer all questions below to the best of your knowledge. Indicate by marking YES or NO if any of the questions apply to you or to any Related Party. Please attach supplementary pages if you have additional disclosures that will not fit in the space below.

1. Do you and/or any Related Party currently have, or within the last five (5) years had, ownership, employment, contractual and/or other interest or affiliation in any clinic, medical group, Independent Practice Association (IPA) and/or Health Maintenance Organization?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type

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2. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership, employment, contractual and/or other interest or affiliation in any company, vendor or organization that conducts provider peer review, credentialing/re-credentialing, quality assurance, utilization review medical record review, hearing officer/judicial review committee services, expert witness services and/or similar activities or services?

□ Yes □ No

If yes, please complete the information below.

Entity	**Your Role**	**Nature of Services**

3. Do you or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any payment(s) or other remuneration from a pharmaceutical, medical device or supply, biotechnology, or medical consulting, manufacturing or distributing company (including, but not limited to, any salary, commission, advance, interest, rent, gift, loan, loan forgiveness, payment of indebtedness, rebate, payment or reimbursement of expenses, fees for consulting, speaker's bureaus, advisory boards or other committees)?

□ Yes □ No

If yes, please complete the information below.

Entity	**Role**	**Remuneration Type**

4. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any equity, including stock, stock options, or venture capital funds from a pharmaceutical, medical device, biotechnology, or medical consulting, manufacturing or distributing company? (Mutual funds and publicly traded stock are excluded).

□ Yes □ No

If yes, please complete the information below.

Entity	Role	Remuneration Type

5. Do you and/or any Related Party currently have, or within the last five (5) years had, rights to medical intellectual property, including patent rights or royalty income?

□ Yes □ No

If yes, please complete the information below.

Entity	Nature and Amount of Interest	Medical Company

6. Do you and/or any Related Party receive any payment(s) or other remuneration for research, including any grants within the last five (5) years?

□ Yes □ No

If yes, please complete the information below.

Entity	Role	Remuneration Type

7. Do you and/or any Related Party currently hold, or within the last five (5) years held, any position as an officer, director, partner, or manager in a hospital, ambulatory surgery center, pharmaceutical, medical device, or biotechnology manufacturing, distributing, or consulting company?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type	Annual Dollar Value

8. Do you have any other potential or actual Conflict(s) of Interest?

   □ Yes □ No

   If yes, please describe below.

   _____
   _____
   _____

I acknowledge and agree that I have received, reviewed, understand and will comply with, CalOptima's Conflictss of Interest Policy No. _____. 1656 I further acknowledge and agree that I have disclosed all known Conflicts of Interest below.

By my signature below, I understand and acknowledge that I have an ongoing obligation to disclose any known Conflicts of Interest that arise while participating in any capacity in the Quality Improvement and/or Utilization Management Departments and/or during my participation on any CalOptima Quality Improvement and/or Utilization Management committee or subcommittee and that I will promptly disclose the existence and nature of any potential or actual Conflicts of Interest.

Signature: _____

Date: _____

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CALOPTIMA CONFLICT OF INTEREST DISCLOSURE FORM

Quality Improvement and Utilization Management Departments, Committees and Subcommittees

Name: _____

Department\Organization: _____

Committee/Subcommittee: _____

Please complete the information below. The terms "Conflict of Interest" and "Related Party" as used in this Conflict of Interest Disclosure Form are defined below.

Definitions:

A. **Conflict of Interest**: A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.

B. **Related Party**: The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent**.**

Conflict of Interest Disclosures:

Please answer all questions below to the best of your knowledge. Indicate by marking YES or NO if any of the questions apply to you or to any Related Party. Please attach supplementary pages if you have additional disclosures that will not fit in the space below.

1. Do you and/or any Related Party currently have, or within the last five (5) years had, ownership, employment, contractual and/or other interest or affiliation in any clinic, medical group, Independent Practice Association (IPA) and/or Health Maintenance Organization?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type

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2. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership, employment, contractual and/or other interest or affiliation in any company, vendor or organization that conducts provider peer review, credentialing/re-credentialing, quality assurance, utilization review medical record review, hearing officer/judicial review committee services, expert witness services and/or similar activities or services?

□ Yes □ No

If yes, please complete the information below.

Entity	**Your Role**	**Nature of Services**

3. Do you or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any payment(s) or other remuneration from a pharmaceutical, medical device or supply, biotechnology, or medical consulting, manufacturing or distributing company (including, but not limited to, any salary, commission, advance, interest, rent, gift, loan, loan forgiveness, payment of indebtedness, rebate, payment or reimbursement of expenses, fees for consulting, speaker's bureaus, advisory boards or other committees)?

□ Yes □ No

If yes, please complete the information below.

Entity	**Role**	**Remuneration Type**

4. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any equity, including stock, stock options, or venture capital funds from a pharmaceutical, medical device, biotechnology, or medical consulting, manufacturing or distributing company? (Mutual funds and publicly traded stock are excluded).

□ Yes □ No

If yes, please complete the information below.

Entity	Role	Remuneration Type

5. Do you and/or any Related Party currently have, or within the last five (5) years had, rights to medical intellectual property, including patent rights or royalty income?

□ Yes □ No

If yes, please complete the information below.

Entity	Nature and Amount of Interest	Medical Company

6. Do you and/or any Related Party receive any payment(s) or other remuneration for research, including any grants within the last five (5) years?

□ Yes □ No

If yes, please complete the information below.

Entity	Role	Remuneration Type

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7. Do you and/or any Related Party currently hold, or within the last five (5) years held, any position as an officer, director, partner, or manager in a hospital, ambulatory surgery center, pharmaceutical, medical device, or biotechnology manufacturing, distributing, or consulting company?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type	Annual Dollar Value

8. Do you have any other potential or actual Conflict(s) of Interest?

   □ Yes □ No

   If yes, please describe below.

   _____
   _____
   _____

I acknowledge and agree that I have received, reviewed, understand and will comply with, CalOptima's Conflicts of Interest Policy No. 1656 I further acknowledge and agree that I have disclosed all known Conflicts of Interest below.

By my signature below, I understand and acknowledge that I have an ongoing obligation to disclose any known Conflicts of Interest that arise while participating in any capacity in the Quality Improvement and/or Utilization Management Departments and/or during my participation on any CalOptima Quality Improvement and/or Utilization Management committee or subcommittee and that I will promptly disclose the existence and nature of any potential or actual Conflicts of Interest.

Signature: _____

Date: _____

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

7. Consider Approval of CalOptima Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer to approve new Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest.

Background

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer or employed position in the Quality Improvement (QI) or Utilization Management (UM) departments or otherwise carrying out quality improvement or utilization management oversight activities, including but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities, fully disclose any actual, perceived, or potential Conflicts of Interest (s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statutes and regulations.

On an annual basis each participant involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have a potential to create a Conflict of Interest for the participant.

Discussion

This new Conflict of Interest policy was developed in response to a DHCS/CMS contract requirement which states that the CalOptima Quality Improvement Committee is responsible for maintaining a process to ensure rules of confidentiality in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members. CalOptima has a policy to ensure rules of confidentiality are met (GG.1620), and CalOptima has an existing Human Resource policy (GA.8012) that ensures that all designated CalOptima employees in positions listed in the CalOptima Conflict of Interest Code shall complete Form 700 Statement of Economic Interest and the Supplement to Form 700. Designated employees include employees who make decisions which foreseeably may have a substantial economic impact. This policy however is applicable only to CalOptima designated employees and members of the Board of Directors. Therefore, a new policy was created to ensure that the Quality Improvement Committee and its subcommittees, who oversight quality and utilization activities, fully disclose any actual or perceived conflicts of interest. The Quality Improvement

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Committee and subcommittee members will annually sign a Conflict of Interest attestation as well as a CalOptima Conflict of Interest Disclosure Form.

Fiscal Impact
There is no fiscal impact for the recommended action to approve the Conflict of Interest Policy.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
CalOptima Policy GG.1656: Quality Improvement and Utilization Management Conflicts of Interest policy with three attachments:

1. Conflict of Interest Attestation (Quality Improvement Committee/Subcommittee(s)
2. Conflict of Interest and Non-Discrimination Attestation (Credentialing and Peer Review Committee)
3. CalOptima Conflict of Interest Disclosure Form

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

2/21/2018 — **Date**

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Policy #:	GG.1656
Title:	**Quality Improvement and Utilization Management Conflicts of Interest**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer, or employed position in the Quality Improvement (QI) or Utilization Management (UM) Departments or otherwise carrying out quality improvement or utilization management oversight activities, including, but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities fully disclose any actual, perceived, or potential Conflicts of Interest(s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statues, and regulations.

II. POLICY

A. It is the policy of CalOptima to promote the best interests of its Members. All decisions concerning the safe care, quality of treatment, and services provided to CalOptima's Members must be made solely with the intent to meet the needs of those Members and without any actual, perceived, or potential conflicts of interest. Under no circumstances may a Participant place his/her own financial interests above the welfare of CalOptima's Members.

B. Participants shall conduct their affairs so as to avoid or minimize Conflicts of Interest, and must appropriately disclose when Conflicts of Interest arise.

C. Participants have a continuing obligation to disclose the existence and nature of any actual, perceived, or potential Conflicts of Interest to CalOptima in accordance with this Policy.

D. The Chief Medical Officer and/or committee chairperson shall evaluate all Conflicts of Interest and determine whether a Conflict of Interest exists, with the assistance of legal counsel, as necessary. The Chief Medical Officer and/or committee chairperson will resolve all conflicts and impose safeguards, as necessary, to appropriately manage Conflicts of Interest.

E. Delegated Health Networks shall have policies and procedures consistent with this policy in order to identify, avoid and/or manage Conflicts of Interest, as appropriate.

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III. PROCEDURE

A. Conflict of Interest

1. A Conflict of Interest depends on the situation and not on the character of the individual. Conflicts of Interest may arise where a Participant and/or a Related Party or an entity directly controlled by them:

   a. Receives material compensation (e.g., gifts, grants, stipends, amenities) from any individual (and/or his employer) or entity that is the subject of a CalOptima QI or UM review;
   b. Has an ownership interest in any entity that is the subject of a CalOptima QI or UM review;
   c. Has a past or present personal relationship with the subject of a CalOptima QI or UM review; and/or
   d. Has a financial interest in any consultant that is engaged and/or contracted by CalOptima to assist it with a QI or UM review and/or investigation.

2. The following are examples of Conflicts of Interest:

   a. A Participant considers or makes decisions with respect to a credentialing or peer review matter where the provider who is the subject of the peer review matter is a direct competitor of the Participant or an individual with whom the Participant previously had a personal, employment, or financial relationship.

   b. A Participant has an ownership or financial interest in the consulting firm engaged by CalOptima to review medical records in connection with a peer review matter.

   c. A Participant receives monetary or non-monetary compensation from a Pharmaceutical manufacturer whose drug is reviewed for listing on the CalOptima Formulary.

   d. A Participant holds a fiscal or management position or role at CalOptima and participates in utilization management decisions (e.g., approving, modifying, deferring, or denying requested services, establishing drug formularies, conducting drug utilization reviews).

   e. A Participant considers and makes decisions regarding the CalOptima credentialing application of a physician where the Participant was a member of a judicial review committee that ruled on a prior hospital peer review matter involving the same physician.

B. Conflict of Interest Disclosure Process

1. On an annual basis, each Participant who is involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the Participant.

2. Upon appointment and prior to serving on any QI or UM committee or subcommittee, each Participant shall sign a Conflict of Interest Attestation and complete a Conflict of Interest

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Disclosure Form, identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a Conflict of Interest for the Participant.

3. If a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest prior to a committee, or subcommittee, meeting, he/she will provide written notice to the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual Conflict of Interest.

4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict of Interest during a committee, or subcommittee, meeting, he/she will immediately alert the committee, or subcommittee, chairperson that he/she may have a potential, perceived, or actual Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may answer, any questions concerning the Conflict of Interest.

5. In all other situations, whenever a Participant realizes that he/she may have a potential or actual Conflict of Interest, he/she will provide written notice to the Chief Medical Officer disclosing the potential, perceived, or actual Conflict of Interest.

6. To the extent the QI Department and/or UM Department engages an external reviewer or expert consultant for peer review or other QI or UM purposes, that individual shall be required to sign a Conflict of Interest Statement and complete a Conflict of Interest Disclosure Form prior to performing any services for CalOptima.

B. Management and Resolution of the Conflicts of Interest

1. The Chief Medical Officer or the committee chairperson will review and evaluate all written disclosures thoroughly for conflicts. For any decision involving a CalOptima employee, the Chief Medical Officer shall involve Legal Counsel before taking any action.

2. The applicable committee or subcommittee chairperson shall resolve any issue over the existence of a Conflict of Interest involving a Participant who is a committee or subcommittee member. All other Conflict of Interest issues shall be resolved by the Chief Medical Director. CalOptima shall verify that no unresolved Conflicts of Interest exist prior to retaining the external reviewer or expert consultant.

3. If it is determined that there is no conflict, then the Participant can continue to be involved in the matter, subject to any limitations imposed by the Chief Medical Officer or committee or subcommittee chairperson.

4. If it is determined that there is a Conflict of Interest, the Participant may be excluded from participation in the matter that gave rise to the Conflict of Interest.

5. The committee chairperson and/or Chief Medical Officer may resolve the conflict, if and when appropriate, by imposing limitations in where there is a determination that a Conflict of Interest does not prohibit the Participant's continued involvement in the matter. These limitations may include, but are not limited to, requiring that the Participant abstain from voting with regard to the matter, or prohibiting the Participant from participating in any investigation of the matter.

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6. If a Participant disagrees with a committee chairperson's decision regarding a Conflict of Interest, he/she can request that the Chief Medical Officer review the Conflict of Interest.

D. Record Retention

1. The Quality Improvement and Utilization Management Departments, as applicable, shall keep copies of all Conflict of Interest Disclosure Forms and any written information disclosing a Conflict of Interest in accordance with applicable regulatory record retention requirements.

2. Credentialing and Peer Review Committee (CPRC) minutes shall reflect the disclosure of Conflicts of Interest and any abstentions from voting on actions.

E. Non-Compliance with Conflicts of Interest Policy

1. Suspected violations of this Policy should be reported to the Chief Medical Officer . Such reports may be made confidentially.

2. The failure of a Participant to disclose a Conflict of Interest when it is known or reasonably should be known to the Participant may result in actions against the Participant, including, but not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a committee or subcommittee. The matter may also be referred to the CalOptima Office of Compliance and/or Human Resources Department for further action as appropriate.

IV. ATTACHMENTS

A. Conflict of Interest Attestation
B. Conflict of Interest and Non-Discrimination Attestation (CPRC)
C. Conflict of Interest Disclosure Form

V. REFERENCES

A. Cal MediConnect Quality Improvement TAG QI-001
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and DHCS for Cal MediConnect
F. Health and Safety Code §1367(g)
G. Title 42, Code of Federal Regulations (C.F.R.), §422.205
H. Title 28, California Code of Regulations, §1300.67.3

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

TBD

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1656	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Conflict of Interest	A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.
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.
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.
Member	An enrollee-beneficiary of a CalOptima program.
Participant	Any individual serving in an appointed, volunteer, or employed position in CalOptima QI and/or UM Departments and/or on any QI or UM committees or subcommittees. This includes, but is not limited to, those individuals making decisions in connection with member quality of care complaints and grievances, provider credentialing and re-credentialing, and/or peer review activities.
Related Party	The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent.

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Conflict of Interest Attestation

[Quality Improvement Committee/Sub-Committee(s)]

I, _____, agree and attest as follows:

1. I am a member of the following CalOptima [Quality Improvement Committee/Sub-Committee(s)]: _____.

2. I understand CalOptima requires that all individuals who serve on [Quality Improvement Committee/Sub-Committee(s)] or who otherwise make decisions on quality oversight and activities ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

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4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's patients must be made solely with the intent to meet the needs of those patients and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima's patients.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.,* abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

_____

Signature

_____

Printed Name

_____

Date

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Conflict of Interest and Non-Discrimination Attestation

Credentialing and Peer Review Committee

I, _____, agree and attest as follows:

1. I am a member of the CalOptima Credentialing and Peer Review Committee (CPRC).

2. I understand CalOptima requires that all individuals who serve on the CPRC ("Participant"), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:

    a. when there is a divergence between the Participant's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;

    b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant's immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent), or the Participant's employers, partners, or other business associates; and

    c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.

5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima members.

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6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.

7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.

8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (*e.g.,* abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

9. I acknowledge that Federal law prohibits CalOptima from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.

10. I acknowledge and understand that I may not base credentialing or re-credentialing recommendations or decisions and/or peer review recommendations or decisions on a provider's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against any CalOptima provider in making such recommendations or decisions.

_____

Signature

_____

Printed Name

_____

Date

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CALOPTIMA CONFLICT OF INTEREST DISCLOSURE FORM

Quality Improvement and Utilization Management Departments, Committees and Subcommittees

Name: _____

Department: _____

Committee/Subcommittee: _____

Please complete the information below. The terms "Conflict of Interest" and "Related Party" as used in this Conflict of Interest Disclosure Form are defined below.

Definitions:

A. **Conflict of Interest**: A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.

B. **Related Party**: The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in, law, or the spouse of a grandparent**.**

Conflict of Interest Disclosures:

Please answer all questions below to the best of your knowledge. Indicate by marking YES or NO if any of the questions apply to you or to any Related Party. Please attach supplementary pages if you have additional disclosures that will not fit in the space below.

1. Do you and/or any Related Party currently have, or within the last five (5) years had, ownership, employment, contractual and/or other interest or affiliation in any clinic, medical group, Independent Practice Association (IPA) and/or Health Maintenance Organization?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type

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2. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership, employment, contractual and/or other interest or affiliation in any company, vendor or organization that conducts provider peer review, credentialing/re-credentialing, quality assurance, utilization review medical record review, hearing officer/judicial review committee services, expert witness services and/or similar activities or services?

□ Yes □ No

If yes, please complete the information below.

Entity	**Your Role**	**Nature of Services**

3. Do you or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any payment(s) or other remuneration from a pharmaceutical, medical device or supply, biotechnology, or medical consulting, manufacturing or distributing company (including, but not limited to, any salary, commission, advance, interest, rent, gift, loan, loan forgiveness, payment of indebtedness, rebate, payment or reimbursement of expenses, fees for consulting, speaker's bureaus, advisory boards or other committees)?

□ Yes □ No

If yes, please complete the information below.

Entity	**Role**	**Remuneration Type**

4. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any equity, including stock, stock options, or venture capital funds from a pharmaceutical, medical device, biotechnology, or medical consulting, manufacturing or distributing company? (Mutual funds and publicly traded stock are excluded).

□ Yes □ No

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If yes, please complete the information below.

Entity	Role	Remuneration Type

5. Do you and/or any Related Party currently have, or within the last five (5) years had, rights to medical intellectual property, including patent rights or royalty income?

□ Yes □ No

If yes, please complete the information below.

Entity	Nature and Amount of Interest	Medical Company

6. Do you and/or any Related Party receive any payment(s) or other remuneration for research, including any grants within the last five (5) years?

□ Yes □ No

If yes, please complete the information below.

Entity	Role	Remuneration Type

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7. Do you and/or any Related Party currently hold, or within the last five (5) years held, any position as an officer, director, partner, or manager in a hospital, ambulatory surgery center, pharmaceutical, medical device, or biotechnology manufacturing, distributing, or consulting company?

   □ Yes □ No

   If yes, please complete the information below.

Entity	Role	Remuneration Type	Annual Dollar Value

8. Do you have any other potential or actual Conflict(s) of Interest?

   □ Yes □ No

   If yes, please describe below.

   _____
   _____
   _____

I acknowledge and agree that I have received, reviewed, understand and will comply with, CalOptima's Conflicts of Interest Policy No. _____. I further acknowledge and agree that I have disclosed all known Conflicts of Interest below.

By my signature below, I understand and acknowledge that I have an ongoing obligation to disclose any known Conflicts of Interest that arise while participating in any capacity in the Quality Improvement and/or Utilization Management Departments and/or during my participation on any CalOptima Quality Improvement and/or Utilization Management committee or subcommittee and that I will promptly disclose the existence and nature of any potential or actual Conflicts of Interest.

Signature: _____

Date: _____

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Policy:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	10/01/2005
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative - External

I. PURPOSE

This policy describes CalOptima's Quality Improvement Committee (QIC) and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for Members and Providers; satisfaction for Members and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the National Committee for Quality Assurance (NCQA).

II. POLICY

A. The Quality Improvement Committee (QIC) shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The QIC shall:

1. Ensure and improve the quality of Member care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to Members, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality in order to:

   a. Improve quality of care received by Members;

   b. Increase Member satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of Member care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

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f. Collect clear, accurate, and appropriate ~~date~~ data to analyze problems and measure improvement; and

g. Coordinate and communicate department-specific and system-wide organizational information.

B. The QIC shall use a variety of Quality Improvement (QI) methodologies dependent on the type of opportunity for improvement identified (i.e., Plan/Do/Study/Act model).

III. PROCEDURE

A. Membership

1. The QIC Chairperson shall be the CalOptima Chief Medical Officer, or Designee~~, CalOptima~~.

2. The voting members shall consist of:

a. A minimum of f~~F~~our (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners;

~~a.~~b. County -Behavioral Health ~~County~~ Representative;

~~b.~~c. CalOptima Chief Medical Officer (CMO) or Designee (Chair)~~; or Designee);~~

d. CalOptima Medical Directors;

e. CalOptima Behavioral Health Medical Director ~~(O~~or Designee~~);~~

~~c.~~f. Executive Director of Quality and Population Health Management;

~~d.~~g. Executive Director of Clinical Operations;

~~e.~~h. Executive Director of Network Management~~; and~~

~~f.~~i. Executive Director of Operations.

3. The QIC shall be supported by:

~~Executive Director of Quality and Population Health Management;~~

~~b.~~a. Director of Quality Improvement;

~~c.~~b. Director of Quality Analytics;

~~d.~~c. Director of~~,~~ Population Health Management

~~e.~~d. Committee recorder, as assigned.

B. Quorum

1. A quorum consists of a minimum of six (6) voting members of which at least four (4) voting members who are physicians or practitioners. Once a quorum is attained, the meeting may

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proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as the attendance in person or participation by telephone.

C. The QIC shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating members of the QIC shall complete the Committee C~~c~~onfidentiality Attestation and Confidentiality S~~s~~tatement Attendee Signature Sheet~~in~~ in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating members shall sign a Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her Designee shall report QIC activities to the QAC and Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee ~~Flow Chart~~Structure Diagram
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/23/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
09/18/2019	Regular Meeting of the CalOptima Quality Assurance Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.7002	Quality Improvement Committee	Medi-Cal
Revised	04/01/2013	GG.1620	Quality Improvement Committee	Medi-Cal OneCare
Revised	08/01/2015	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Member	An enrollee-beneficiary of a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Plan-Do-Study-Act (PDSA)	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, pPhysician ~~Medical Group~~group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

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Policy:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	10/01/2005
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative - External

I. PURPOSE

This policy describes CalOptima's Quality Improvement Committee (QIC) and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for Members and Providers; satisfaction for Members and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the National Committee for Quality Assurance (NCQA).

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A. The Quality Improvement Committee (QIC) shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The QIC shall:

1. Ensure and improve the quality of Member care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to Members, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality in order to:

   a. Improve quality of care received by Members;

   b. Increase Member satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of Member care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

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f. Collect clear, accurate, and appropriate data to analyze problems and measure improvement; and

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2. The voting members shall consist of:

a. A minimum of four (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners;

b. County Behavioral Health Representative;

c. CalOptima Chief Medical Officer (CMO) or Designee (Chair);

d. CalOptima Medical Directors;

e. CalOptima Behavioral Health Medical Director or Designee;

f. Executive Director of Quality and Population Health Management;

g. Executive Director of Clinical Operations;

h. Executive Director of Network Management;

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3. The QIC shall be supported by:

a. Director of Quality Improvement;

b. Director of Quality Analytics;

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d. Committee recorder, as assigned.

B. Quorum

1. A quorum consists of a minimum of six (6) voting members of which at least four (4) voting members who 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 the attendance in person or participation by telephone.

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C. The QIC shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating members of the QIC shall complete the Committee Confidentiality Attestation and Confidentiality Statement Attendee Signature Sheet in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating members shall sign a Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her Designee shall report QIC activities to the QAC and Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee Structure Diagram
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY APPROVAL(S)

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Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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Term	Definition
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Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to modify existing Policies and Procedures, as follows:
1. GG.1607: Monitoring Adverse Actions
2. GG.1608: Full Scope Site Reviews
3. GG.1620: Quality Improvement Committee
4. GG.1639: Post-Hospital Discharge Medication Supply

Background/Discussion
As a County Organized Health System (COHS), CalOptima contracts with state and federal agencies to provide health care services to beneficiaries in Orange County.

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified laws, regulatory guidance, contracts and business practices as part of its annual policy review process and on an ad hoc basis.

CalOptima regularly reviews its Policies and Procedures to ensure they are up to date and aligned with federal and state health care program requirements and laws as well as CalOptima operations. CalOptima staff have reviewed the Policies and Procedures to ensure consistency with applicable federal and state health care program laws, regulations and/or guidance.

Summary of Changes
CalOptima Policy and Procedure updates include the following, but are not limited to:
- Recent regulatory updates
- Annual review revisions
- Updates to business operations
- National Committee for Quality Assurance (NCQA) standards

The following table lists new and/or modified policies that are presented for approval:

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	Policy	Summary of Change(s)	Reason for Change
1.	GG.1607: Monitoring Adverse Actions	Policy GG.1607 establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and Organizations Providers (OPs). The main change to the policy was including language regarding Center for Medicare & Medicaid Services (CMS) requirement to check the Preclusion List as part of monitoring adverse actions.	• Annual Review; CMS Regulatory requirement
2.	GG.1608: Full Scope Site Reviews	This policy outlines CalOptima's site review requirements, per Department of Health Care Services (DHCS) Policy Letter (PL) 14-004, including the Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS), and the process by which CalOptima conducts, scores, tracks and reports site reviews in accordance with applicable state and federal guidelines. Changes include: • Addition to the policy that CalOptima may collect additional information at primary care provider (PCP) sites during the FSR process including, but 45 not limited to, information on member experience and timely access to Covered Services. • Updated statement that CalOptima must resurvey the PCP, and the PCP must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any Corrective Action Plan (CAP) issued must be completed per CAP timeline requirements. • Updated process related to CalOptima unannounced site visit when one (1) or more member complaints related to physical accessibility or member safety is identified. If any issue related to physical accessibility or member safety, then CalOptima shall conduct an unannounced site visit no later than seven (7) calendar	•Annual Review, Updated business operations, and added more specificity language

	Policy	Summary of Change(s)	Reason for Change
		days after identification, depending on the severity of the identified patient safety or physical accessibility issue. However, for complaints of appearance or cleanliness, will be tracked and trended; if there are more than three (3) in a 12-month period an unannounced site visit will be conducted. • Updated statement that Credentialing and Peer Review Committee (CPRC) will provide updates related to FSR/MRR/PARS to the CalOptima Quality Improvement Committee quarterly.	
3.	GG.1620: Quality Improvement Committee	The policy describes CalOptima's Quality Improvement Committee (QIC) and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for members and providers; satisfaction for members and other customers; maintenance of quality standards, licensing, contract and regulatory compliance; and continued accreditation by the National Committee for Quality Assurance (NCQA). The policy reflects the QIC Charter but had no major changes in 2019.	•Annual Review
4.	GG.1639: Post-Hospital Discharge Medication Supply	Purpose of this policy is to ensure that contracted hospitals provide for members at least a seventy-two (72) hour supply of medication upon discharge when the medication is needed to prevent the member's condition from worsening. The requirement can be met either by providing the seventy-two (72)-hour supply or providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply. Medications normally requiring prior authorization are exempted when needed after hours (nights, weekends and holidays).	•Annual Review

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Fiscal Impact
The recommended action to adopt modifications to CalOptima's Quality Improvement policies and procedures based on the annual policy review has no additional fiscal impact on the CalOptima Fiscal Year 2019-20 Operating Budget.

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 versions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. GG.1607: Monitoring Adverse Actions (redlined and clean versions)
2. GG.1608: Full Scope Site Reviews (redlined and clean versions)
3. GG.1620: Quality Improvement Committee (redlined and clean versions)
4. GG.1639: Post-Hospital Discharge Medication Supply (redlined and clean versions)

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

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Policy #:	GG.1607Δ
Title:	**Monitoring Adverse ~~Activities~~Actions**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	TBD~~06/01/17~~
Last Revised Date:	TBD~~06/01/17~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process for ongoing monitoring of ~~contracted~~the actions taken by external entities including, without limitation, licensing boards or ~~non-contracted~~agencies, regulatory agencies and/or other entities against CalOptima practitioners ~~and~~or Healthcare Delivery ~~Organization's~~Organizations (HDOs~~) Adverse Activity.~~).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

~~B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles that at a minimum, is in accordance with this Policy.~~

~~C. CalOptima shall take appropriate action against practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies adverse activity.~~

~~D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.~~

~~E.~~B. Adverse ~~Activities~~actions include~~-~~, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 ~~report~~ with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

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4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG); ~~or~~

9. Any action taken by System for Award Management (SAM~~); or~~); or~~.~~

~~9.~~10. Any provider listed on the CMS Preclusion List.

~~10. A pattern or trend concerning quality of care issues and complaints that have been identified through the CalOptima Quality Improvement Department.~~

C. CalOptima shall refer information of adverse actions taken against CalOptima practitioners or HDOs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing and Peer Review Committee for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in Federal or State health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify ~~Adverse Activities~~adverse actions that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for ~~Adverse Activity(ies)~~adverse actions including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis; ~~and~~

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6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions~~.~~; ~~and~~

7. California State Licensing Boards for all practitioners within FACETS; checked monthly and quarterly as reports are published;~~.~~

8. CMS Preclusion List as published by CMS, upon Credentialing and Recredentialing, and ongoing on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse ~~activity that limits or removes a practitioner's right to practice will be reported~~actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the ~~Quality~~CalOptima Medical Director ~~for approval. Once approved, the~~, Provider Relations ~~or~~, Health Network Relations ~~Departments will be notified. In addition,~~ , and Provider Data Management ~~Services~~Systems (PDMS~~) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.~~).

~~E. Any adverse activities identified shall be tracked in the adverse activity database.~~

~~F.~~E. Upon credentialing and recredentialing, adverse ~~activities~~actions identified in the tracking database will be summarized and added to the practitioner and HDO file ~~in Credentialing database~~.

~~G.~~F. ~~On a bi-monthly basis or earlier, depending on the nature of the adverse activity and CalOptima requirements, the~~ QI Department shall report, in a confidential manner, all adverse action findings to the Credentialing Peer Review Committee (CPRC).

~~H.~~G. ~~On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department~~ CalOptima shall ~~report to the Quality Improvement Committee (QIC) all complaints, including a summary of~~also monitor and consider internal quality data ~~analysis, regarding service, attitude, and access,~~(e.g. potential quality issues (PQIs), and Member grievances between re-credentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

~~I.~~H. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

~~J.~~I. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

~~K.~~J. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files~~,~~ and shall ensure that all Credentialing files are up-to-date.

~~L.~~K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

~~a.~~1. The report to DHCS shall include the following:

~~i.~~a. Contract status (by delegated entity, if applicable) with the named provider.

~~ii.~~b. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

~~M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.~~

~~N.~~L. ~~Any alert~~Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
~~B. California Business and Professions Code, §4022~~
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~A. ~~CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage~~
~~E.~~D. CalOptima PACE Program Agreement
~~F.~~E. CalOptima Policy CMC.9001: Member Complaint Process
~~G.~~F. CalOptima Policy CMC.9002: Member Grievance Process
~~H.~~G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
~~I.~~H. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~J.~~I. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
~~K.~~J. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
~~L.~~K. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~M.~~L. CalOptima Policy HH.1102: CalOptima Member Complaint
~~N.~~M. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
~~O.~~N. CalOptima Policy MA.9002: Member Grievance Process
~~P.~~O. CalOptima Policy MA.9006: Provider Complaint Process
~~Q.~~P. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~R.~~Q. Department of Health Care Services All Plan Letter 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
~~S.~~R. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 08/04/17: Department of Health Care Services

VII. BOARD ACTIONS

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A.— ___06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 11/29/18: Regular Meeting of the Credentialing Peer Review Committee
C. 02/12/19: Regular Meeting of the Quality Improvement Committee
D. 09/18/19: Regular Meeting of the Quality Assurance Committee

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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.
Long Term Support Services (LTSS) Providers	A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

Policy #:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	TBD
Last Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima practitioners or Healthcare Delivery Organizations (HDOs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

B. Adverse actions include, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG);

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9. Any action taken by System for Award Management (SAM); or

10. Any provider listed on the CMS Preclusion List.

C. CalOptima shall refer information of adverse actions taken against CalOptima practitioners or HDOs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing and Peer Review Committee for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in Federal or State health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify adverse actions that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all practitioners within FACETS; checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS, upon Credentialing and Recredentialing, and ongoing on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS).

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E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the practitioner and HDO file.

F. QI Department shall report, in a confidential manner, all adverse action findings to the Credentialing Peer Review Committee (CPRC).

G. CalOptima shall also monitor and consider internal quality data (e.g. potential quality issues (PQIs), and Member grievances between re-credentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

H. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

J. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files and shall ensure that all Credentialing files are up-to-date.

K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

1. The report to DHCS shall include the following:

a. Contract status (by delegated entity, if applicable) with the named provider.

b. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy CMC.9001: Member Complaint Process

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F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1611: Potential Quality Issue Review Process
I. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
J. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
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O. CalOptima Policy MA.9006: Provider Complaint Process
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Q. Department of Health Care Services All Plan Letter 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
R. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

A. 08/04/17: Department of Health Care Services

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 11/29/18: Regular Meeting of the Credentialing Peer Review Committee
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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
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Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **~~Enforcement Public Document Search (Search by Name or Lic: http://www2.mbc.ca.gov/PDL/Search.aspx~~**	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final

Ongoing Monitoring Website Information ~~01-25-2017~~

Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov ~~Enforcement/Disciplines(916) 9288390 Ext. 6~~	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** ~~**Subscribe to e-mail Alerts**~~ ~~**http://www.ombc.ca.gov/consumers/enforce_action.shtml**~~	Quarterly via the Website E-Mail Distribution list:
~~**Licensing Board, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website/links**~~	~~**Report Frequency**~~

Revised 0~~5-01-18~~~~1 25 2017~~, Revised 12/21/18-, Revised 1/11/2019
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

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Ongoing Monitoring Website Information ~~01-25-2017~~

Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 ~~Email: BPM@dca.ca.gov~~ ~~Enforcement Program~~ ~~Central File Room~~ ~~Medical Board of California~~ ~~2005 Evergreen Street, Suite 1200~~ ~~Sacramento, CA 95815~~ ~~FAX: (916) 263-2420~~	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. ~~History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses~~ varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 ~~Email: acupuncture@dca.ca.gov~~ ~~To order copies of actions send to Attn of Consumer Protection Program~~	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**~~	Monthly running report listed Alpha Newer actions highlighted with date in blue. ~~Note: Board meetings are held quarterly.~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 ~~E-Mail:~~ ~~BBSWebmaster@bbs.ca.gov~~	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** ~~**Sign up for subscribers list for disciplinary actions.**~~ ~~**https://www.dca.ca.gov/webapps/bbs/subscribe.php**~~	**Via Subscriptions Only** Information must be obtained via subscription. Monthly ~~For Subscribers:~~ ~~E-mail reports were sent:~~
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Monthly

Ongoing Monitoring Website Information ~~01-25-2017~~

Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov ~~Enforcement Unit PH: 916-274-6326~~	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	Monthly ~~Note: At the end of the list it provides a date posted.~~ ~~As of 12/31/2016~~

~~Licensing Board, Address and Phone Numbers~~	~~Practitioner Types~~	~~Website~~	~~Report Frequency~~

Ongoing Monitoring Website Information ~~01-25-2017~~

California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 ~~Email: cbot@dca.ca.gov~~ ~~Email: EnfPrg@dca.ca.gov~~	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** ~~**Sign up for subscribers list for disciplinary actions: https://www.dca.ca.gov/webapps/bot/subscribe.php**~~	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. M~~Recommend m~~onthly review. ~~The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**~~	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	Monthly ~~Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.~~

Ongoing Monitoring Website Information ~~01-25-2017~~

Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	**www.psychboard.ca.gov** ~~**Sign up for subscribers list for disciplinary actions:**~~ ~~**https://www.dca.ca.gov/webapps/psychboard/subscribe.php**~~	**Via Subscriptions Only** Information must be obtained via subscription~~.~~ . Varies Monthly ~~For Subscribers:~~ ~~E-mail~~

~~**Licensing Board, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website**~~	~~**Report Frequency**~~
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www rn.ca.gov/enforcement/unlicprac.shtml**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information ~~01-25-2017~~

~~**National Council of State Board of Nursing (BCSBN)**~~ ~~111 East Wacker Drive, Suite 2900~~ ~~Chicago, IL 60601-4277~~ ~~Phone:(312) 525-3600~~ ~~Fax: (312) 279-1032~~ ~~Email: info@ncsbn.org~~ ~~.~~	~~Additional information for RN/LVN/NP/CNM~~	~~**www.nursys.com**~~ ~~To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions.~~ ~~**https://www.nursys.com/EN/ENDefault.aspx**~~	~~.~~
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** ~~As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.~~	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

~~**Site Name, Address and Phone Numbers**~~	~~**Service**~~	~~**Website**~~	~~**Report Frequency**~~
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction &exclusions	**www.oig hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** ~~**Direct Link to exclusion database**~~ ~~**http://oig.hhs.gov/exclusions/exclusions_list.asp**~~	**Monthly** ~~(see note under instructions regarding subscribing notifications)~~

Revised 05-01-18~~1 25 2017~~, Revised 12/21/18~~-~~, Revised 1/11/2019
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

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Ongoing Monitoring Website Information ~~01-25-2017~~

~~Noridian Healthcare Solutions Medicare Opt-Out Physicians JE MAC~~ ~~1855-609-9960 Select Provider Enrollment~~ ~~https://med.noridianmedicare.com/web/jeb~~	~~Medicare Opt-Out~~	~~https://www.noridianmedicare.com~~ ~~Link to JE Part B~~ ~~https://med.noridianmedicare.com/web/jeb~~ ~~Direct Link to Opt-Out Reports: https://med.noridianmedicare.com/web/jeb/enrollment/optout/opt-out-listing~~	~~Quarterly~~ ~~Last update:~~ ~~01/19/17(updated 1/20/17)~~ ~~08/15/16~~ ~~06/13/16 (6/10/16)~~ ~~12/23/15~~ ~~10/30/15 Northern~~ ~~10/08/15 Southern~~ ~~08/14/15~~ ~~07/07/15~~ ~~04/13/15~~ ~~03/11/15~~ ~~01/28/15~~
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	**Quarterly**

Ongoing Monitoring Website Information ~~01-25-2017~~

CMS.gov **Centers for Medicare & Medicaid Services**	**The Preclusion List**	CMS will make the initial Preclusion List available to Plans beginning **January 1, 2019** on a secure website and updates will be made available approximately every 30 days, around the first business day of each month. Details on how it will be distributed to Quality Improvement is TBD.	**Monthly and Upon Initial and Recredentialing Cycle.**

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Report Frequency~~
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**

Ongoing Monitoring Website Information ~~01-25-2017~~

SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** ~~Note: The SAM website has a user guide:~~ ~~Link to SAM User Guide v1.8.3 of 350:~~	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	**Monthly via Lexis Nexist Monitoring ~~NA~~**

Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default htm **To search for a facility** • Enter name in box that is found in top right corner Search or • Link to Advance Search on the left under Login. **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.

Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Instructions and Comments~~

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Additional Websites for Initial and Recredentialing Verifications

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Additional Websites for Initial and Recredentialing Verifications

~~Site Name, Address and Phone Numbers~~	~~Service~~	~~Website~~	~~Instructions and Comments~~

Additional Websites for Initial and Recredentialing Verifications

Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR2016-06-01/html/2016-12479 htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses - **American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** - **American Nurses Credentialing Center** (ANCC) - **National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) - **Pediatric Nursing Certification Board** (PNCB) - **American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa net/**	Informational only to verify board certification	**Board Certification**

Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	http://www.amcbmidwife.org/	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	http://www.abpp.org/	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

e specialty certifying boards are ently approved under California law for : DPMs – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/**	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

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Ongoing Monitoring Website Information

Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	Quarterly via the Website E-Mail Distribution list:

Ongoing Monitoring Website Information

Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml**	Monthly running report listed Alpha Newer actions highlighted with date in blue.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov**	**Via Subscriptions Only** Information must be obtained via subscription. Monthly
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Monthly

Ongoing Monitoring Website Information

Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	Monthly

Ongoing Monitoring Website Information

California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml**	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Monthly review.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	Monthly

Ongoing Monitoring Website Information

Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	**www.psychboard.ca.gov**	**Via Subscriptions Only** Information must be obtained via subscription. Varies Monthly
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www rn.ca.gov/enforcement/unlicprac.shtml**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information

Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml**	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction &exclusions	**www.oig hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/**	**Monthly**
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProvider SupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	**Quarterly**

Ongoing Monitoring Website Information

CMS.gov **Centers for Medicare & Medicaid Services**	**The Preclusion List**	CMS will make the initial Preclusion List available to Plans beginning **January 1, 2019** on a secure website and updates will be made available approximately every 30 days, around the first business day of each month. Details on how it will be distributed to Quality Improvement is TBD.	**Monthly and Upon Initial and Recredentialing Cycle.**

Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**

Ongoing Monitoring Website Information

SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/**	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	**Monthly via Lexis Nexist Monitoring**

Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default htm **To search for a facility** • Enter name in box that is found in top right corner Search or • Link to Advance Search on the left under Login. **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.

Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 05-01-18

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Additional Websites for Initial and Recredentialing Verifications

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Additional Websites for Initial and Recredentialing Verifications

Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR2016-06-01/html/2016-12479 htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses - **American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** - **American Nurses Credentialing Center** (ANCC) - **National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) - **Pediatric Nursing Certification Board** (PNCB) - **American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa net/**	Informational only to verify board certification	**Board Certification**

Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Board Certification, Address and Phone Numbers	**Practitioner Types**	**Website**	**Instructions and Comments**	**Verification Type**
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

e specialty certifying boards are ently approved under California law for : DPMs – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Policy #:	GG.1608Δ
Title:	**Full Scope Site Reviews**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
~~Last Review Date:~~	~~02/01/18~~
~~Last~~ Revised Date:	~~02/01/18~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines CalOptima's site review process, including the **Facility Site Review (FSR)**, **Medical Record Review (MRR)**, and **Physical Accessibility Review Survey (PARS)**, and the process by which CalOptima conducts, scores, tracks, and reports site reviews in accordance with applicable state and federal guidelines.

II. POLICY

A. CalOptima shall assess the quality, safety, and accessibility of sites where care is delivered in accordance with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS) guidelines and regulations.

B. CalOptima may delegate **FSR**, **MRR**, and **PARS** to a Knox-Keene licensed full service health care service plan that is contracted with CalOptima as a **Health Network**. Such delegated health plan shall conduct **FSR**, **MRR**, and **PARS** in accordance with the provisions of this Policy and in compliance with applicable DHCS and CMS guidelines and regulations.

C. CalOptima shall retain responsibility and accountability for the coordination and consolidation of **FSR**, **MRR**, or **PARS** and shall not delegate such reviews to a **Health Network**, except where CalOptima approves a delegation to a full service Knox-Keene licensed **Health Maintenance Organization (HMO)** in accordance with Section II.B of this Policy.

D. CalOptima's Quality Improvement (QI) Department shall conduct **FSR**, **MRR**, and **PARS**, as well as subsequent periodic site reviews, as part of the initial **credentialing** and recredentialing process, regardless of the status of other certification or accreditation, if:

1. There is no documented evidence that the **Primary Care Provider (PCP)** site has a current passing score on a survey conducted by another Medi-Cal Managed Care health plan; or

2. A **PCP** from a certified **PCP** site moves to a new site that has not been previously reviewed.

E. A Full Scope/Periodic Site Review consists of the **FSR** and **MRR**.

1. CalOptima is not required to conduct a **Full Scope Site Review** for a **PCP** site if a new **PCP** is added to a **PCP** site that has a current passing **Full Scope Site Review** score.

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F. **Full** Scope Site Reviews shall be conducted by specified CalOptima staff as outlined in Section III.~~H~~ A of this Policy.

G. CalOptima's QI Department shall conduct a **FSR** for new **PCP** sites that have never received a **FSR** or have not had a passing review in the past three (3) years.

H. CalOptima's QI Department shall conduct a **MRR survey** for new **PCP** sites within ninety (90) calendar days of the date CalOptima first assigns **Members** to the **PCP**~~, except~~. CalOptima may defer the review an additional ninety (90) calendar days only if the new **PCP** ~~has a "shared" medical records system or the site does~~does not have a sufficient number of **Members assigned** to complete a review of ten (10) ~~medical~~**Medical Records.** At the end of six (6) months, if the **PCP** still has fewer than ten (10) assigned **Member Medical Records,** CalOptima must complete an MRR on the total number of records available, and adjust the scoring according to the number of records~~.~~ reviewed.

I. CalOptima's QI Department shall conduct a **PARS** at the time of initial **credentialing** for the following:

1. All **PCP** offices;

2. **Specialty Care Provider** offices, **Community Based Adult Services (CBAS) Provider Sites**, and **Ancillary Service Provider Sites** serving a high volume of **Seniors and Persons with Disabilities (SPD)**; and

3. **Specialty Care Provider** offices and **Ancillary Service Provider Sites** included in the provider directory who are serving a high volume of OneCare Connect **Members**.

J. CalOptima shall conduct a subsequent **FSR**, **MRR**, and **PARS** of a **PCP** site at least every three (3) years.

1. CalOptima may waive ~~a~~an **FSR**, **MRR**, and/or **PARS** for a pre-contracted **PCP** site if the **PCP** site has documented proof that ~~a~~an **FSR**, **MRR**, and/or **PARS** with a passing score was completed by a Medi-Cal Managed Care health plan within the past three (3) years.

2. CalOptima may conduct ~~a~~an **FSR**, **MRR**, and/or **PARS** more frequently if required by local collaborative decision, or if CalOptima determines that it is necessary based on monitoring, evaluation, or **Corrective Action Plan (CAP)** follow-up issues.

K. CalOptima shall monitor a **PCP** site between each regularly scheduled **FSR**.

1. CalOptima shall conduct an ~~Interim Audit~~ interim audit midcycle (approximately eighteen (18) months) after the previous audit date to evaluate the nine (9) Critical Elements from the **FSR**.

a. If there was no **Critical Element CAP** received during the previous audit, the office will receive an attestation to sign and return to CalOptima attesting all Critical Elements are in effect.

b. If the **Critical Elements CAP** was received during the previous audit, an on-site audit will be conducted on the **Critical Elements** only.

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L. CalOptima's QI Department shall score the **FSR**, **MRR**, and **PARS** in accordance with Section III.D of this Policy.

M. CalOptima's QI Department shall identify deficiencies and request **Corrective Action Plans (CAP)** for **FSR** and **MRR** deficiencies, in accordance with Section III.E of this Policy.

1. ~~CAPS~~**CAPs** will not be issued for **PARS** results, as these results are informational.

2. CalOptima shall document **PARS** results and make survey records available to DHCS for review upon request.

N. **Members** shall not receive **Covered Services** at a new **PCP** site until the site receives a passing **FSR** score, as outlined in Section III.D.1 of this Policy, and/or completes required **CAPs** issued by CalOptima's QI Department.

O. Notwithstanding the corrective action time requirements set forth in this Policy, CalOptima shall not allow an existing **PCP** site with major or serious uncorrected deficiencies to continue providing care to **Members** until the site corrects all such deficiencies.

P. All **Health Networks** shall accept CalOptima site review surveys status or results to coordinate and consolidate site audits for shared **PCPs**.

Q. A **PCP** shall notify CalOptima when the **PCP** intends to relocate its practice at least thirty (30) calendar days prior to the relocation. Upon notification of the relocation, CalOptima shall conduct an **FSR**, **MRR**, and **PARS** on the new location, except as described in Section II.E.1 of this Policy.

1. If a PCP notifies CalOptima after the move:

a. CalOptima will permit assigned **Members** to continue to see the PCP;

b. CalOptima will not assign new **Members** to the PCP until CalOptima conducts an **FSR** on the new location; and

c. CalOptima will complete an **FSR** on the new location within thirty (30) calendar days of the notification of the move.

R. The site review process described in this policy shall remain confidential and protected from disclosure in accordance with applicable law.

S. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** Complaints related to physical accessibility or **Member** safety, pursuant to Section III.F of this Policy, are filed with CalOptima's QI Department.

T. CalOptima may collect additional information at **PCP** sites during the **FSR** process, including but not limited to, information on member experience, and timely access to **Covered Services**.

III. PROCEDURE

A. **Facility Site Review:**

1. The **FSR** includes on-site inspection and interviews with site personnel to review criteria outlined by DHCS including, but not limited to, the following nine (9) ~~critical elements~~**Critical Elements** that may adversely affect a **Member's** health or safety:

   a. Exit doors and aisles are unobstructed and escape accessible;

   b. Airway management equipment is appropriate to the practice and populations served (e.g., oxygen delivery systems, oral airways, nasal canula or mask, Ambu bag) and are present on site;

   c. Only qualified and trained personnel retrieve, prepare, or administer medications;

   d. The Physician must review and follow-up with referrals, consultation reports and diagnostic test results;

   e. Only lawfully authorized persons dispense drugs to patients;

   f. Personal Protective Equipment (PPE) is readily available for staff use;

   g. Needlestick safety precautions are practiced on site;

   h. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, and shipping; and

   i. Spore testing of autoclave or steam sterilizer is completed at least monthly with documented results.

B. **Medical Record Review:**

1. CalOptima may conduct the **MRR** at the same time as the **FSR**, or at another mutually agreed-upon time.

   a. CalOptima shall conduct an initial **MRR** within ninety (90) calendar days after the first (1st) day **Members** are assigned to the **PCP**, except if the **PCP** has a "shared" **Medical Records** system, as described in Section III.B.2.b of this Policy.

   b. CalOptima may grant an extension of ninety (90) calendar days if the new **PCP** does not have a sufficient number of **Members** assigned to complete a review of ten (10) **Medical Records**.

   c. If, at six (6) months after the first (1st) day **Members** are assigned to the **PCP**, the **PCP** still has fewer than ten (10) assigned **Member Medical Records**, CalOptima shall conduct a **MRR** of all available **Member Medical Records**.

   d. CalOptima shall adjust the scoring of the **MRR** according to the number of records reviewed.

2.~~-~~ **Medical Record** selection

a. Individual PCP Medical Record system

~~i.~~ The **MRR** is based on a survey standard of ten (10) randomly selected **Medical Records** per **PCP**, consisting of five (5) pediatric and five (5) adult and/adults or obstetric (OB) records.

~~ii.~~i. ~~Prior to initiating the MRR, a Certified Reviewer shall determine the Member populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the PCP site, and shall determine the medical records and audit tools appropriate for the PCP site.~~

~~iii.~~ii. If a **PCP** site has only pediatric, only adult, or only obstetric patients, CalOptima shall conduct the **MRR** on ten (10) records in the preventive care area relevant to the **Member** population served at the **PCP** site.

iii. Prior to initiating the **MRR**, a **Certified Site Reviewer** shall determine the **Member** populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the **PCP** site, and shall determine the **Medical Records** and audit tools appropriate for the **PCP** site.

b. Shared PCP Medical Record system

i. CalOptima shall consider a **PCP** site where documentation of patient care by multiple **PCPs** occurs in the same medical record as a "shared" **Medical Records** system. Shared **Medical Records** shall be considered those that are not identifiable as separate records belonging to any specific **PCP**.

ii. If a new **PCP** joins a **PCP** site that uses a shared **Medical Records** system that has a current passing **MRR** Survey score, CalOptima shall review the new **PCP** according to the periodic review cycle of the **PCP** site.

iii. CalOptima shall select **Medical Records** by random selection, using every other **Medical Record**, as follows:

Number of PCPs at the site	Number of Medical Records to be pulled by the staff	Number of Medical Records to be randomly selected and reviewed
1-3	10-20	10
4-6	20-40	20
7 or greater	30-60	30

a) CalOptima shall select **Medical Records** randomly from all **PCPs** at the site.

b) CalOptima shall select **Medical Records** for CalOptima **Members** only.

c) CalOptima prefers that each **Medical Record** include at least three (3) visits within the twelve (12) months preceding the date of review.

C. **Physical Accessibility Review Survey:**

1. The **PARS** for **PCP** and Specialist sites shall evaluate access for **Members** with disabilities to parking, building, elevator, and restroom facilities. It includes twenty-nine (29) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

2. The **PARS** for ~~Ancillary Provider Sites~~**ancillary provider sites** shall evaluate ancillary facility site access for **Members** with disabilities to parking, building, elevator, restrooms, diagnostic and treatment room/equipment use. It includes thirty-four (34) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

3. The **PARS** for **CBAS** ~~Provider Sites evaluates~~**provider sites** evaluate facility site access for **Members** with disabilities to parking, building, elevator, participant areas, and restrooms. It includes twenty-four (24) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

4. Scoring of the **PARS**:

   a. Physical accessibility shall be determined as Basic or Limited based on the type of site assessment.

   b. To meet Basic Access requirements, all critical elements found in the **PARS** specific to the provider site must be met.

   c. **PCPs**, as well as **Specialty Care Providers**, **Ancillary Service**, and **CBAS** Provider **sites** serving a high volume of **SPD** and OneCare Connect **Members** will receive a deficiency and be classified as Limited Access if one (1) or more of the critical elements of the **PAR Survey** are not met.

5. **PARS** Deficiencies Process:

   a. If deficiencies in one (1) or more of the critical elements are identified, the facility site shall be deemed Limited Access, in accordance with the **PARS**.

      i. CalOptima shall provide a record of deficiencies to the office receiving the **PARS** to maintain compliance with the Americans with Disabilities Act (ADA).

         a) The reviewer will summarize the list of deficiencies and discuss all deficiencies at the exit interview with the **PCP** and will send a summary of deficiencies to the facility manager within forty-five (45) calendar days of the review.

      ii. The office must address all deficiencies and provide reasons why deficiencies will not be corrected to meet ADA requirements.

a) The **PCP** or facility manager shall respond to CalOptima within thirty (30) calendar days of the **PARS** review for how deficiencies will be addressed, including the timeframe and activities for correcting identified deficiencies.

iii. If major construction deficiencies are identified, the office must have the property management company provide a written statement, on their business letterhead, as to why the deficiency cannot be corrected.

iv. Upon receipt of the letter, it will be filed with the **FSR** folder and reported to DHCS upon request.

v. If the deficiencies are minor and within reason to correct and the provider refuses to make the corrections the issue will be taken to **Credentialing and Peer Review Committee (CPRC)** for discussion and a decision.

6. CalOptima shall publish physical accessibility indicators including, but not limited to, level of access results met per provider site as either Basic Access or Limited Access, in the Provider Directory and Web-based Directory.

D. **Facility Site Review** and **Medical Record Review** Survey Scoring

1. Scoring of the **FSR** and **MRR**:

a. **FSR** and **MRR** shall only be completed and scored by designated personnel, in accordance with Section III.~~H~~ I of this Policy.

b. To pass a **Full Scope Site Review**, a **PCP** site shall achieve a minimum score of eighty percent (80%) on both the **FSR** and the **MRR**.

i. CalOptima shall not average the **FSR** and the **MRR** scores.

ii. A score below eighty percent (80%) on either the **FSR** or **MRR** shall be considered a non-passing **Full Scope Site Review** score.

c. CalOptima shall award only full point value for any scored element on the **FSR** or **MRR**. CalOptima shall not award any partial points.

i. If an element does not fully meet criteria, the **Certified Site Reviewer** shall give a score of zero (0) for that element.

ii. The **Certified Site Reviewer** shall determine the "not applicable" status of a criterion based on the relevance to the **Member** population served at the **PCP** site, and the site-specific assessment.

iii. The **Certified Site Reviewer** shall document a written explanation for every score of zero (0) points, and every criterion determined as "not applicable".

d. After completing the **FSR** and **MRR**, the **Certified Site Reviewer** shall calculate the **PCP** site score in each survey to determine the compliance rate and the need for follow-up.

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e. The minimum passing score for the **FSR** ~~and MRR~~ is eighty percent (80%) of the total points available. A **PCP** site may earn up to one hundred fifty (150) points for a site review with the following compliance level categories:

Compliance Categories	Compliance Rate
Exempted Pass	Ninety percent (90%) or above without deficiencies in critical elements, pharmaceutical services, or infection control
Conditional Pass	Eighty to eighty-nine percent (80-89%); or Ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control
Not Pass	Below eighty percent (80%)

f. N/A applies to any scored item that does not apply to a specific site, as determined by the Certified Site Reviewer.

g. The **MRR** contains three (3) general categories of Format, Documentation, and Coordination/Continuity of Care, and three (3) specific preventive categories of Pediatric Preventive, Adult Preventive, and OB/CPSP. **PCP** sites may earn up to twenty-three (23) points for the three (3) general categories multiplied by the number of ~~medical records~~**Medical Records** reviewed, plus the points given for the preventive services categories, as follows:

i. Pediatric Preventive: Nineteen (19) points multiplied by the number of pediatric ~~medical records~~**Medical Records** reviewed;

ii. Adult Preventive: Fifteen (15) points multiplied by the number of adult ~~medical records~~**Medical Records** reviewed; and

iii. OB/CPSP: Twenty (20) points multiplied by the number of OB/CPSP ~~medical records~~**Medical Records** reviewed.

~~h. PCP sites may earn a full point if the scored element meets the applicable criteria. CalOptima must not award partial points for any scored element that the reviewer considers only "partially" met. PCP sites must earn zero points if an element does not meet the applicable criteria. The reviewer must determine the "not applicable" (N/A) status of each criterion based on a site-specific assessment. The Certified Site Reviewer must explain all criteria scored as zero points or assessed as N/A. The MRR compliance levels are as follows:~~

h. The **MRR** compliance levels are as follows:

Compliance Categories	Compliance Rate
Exempted Pass	Ninety percent (90%) or above: Total score is >90% and all section scores are eighty percent (80~~%~~%) or above
Conditional Pass	Eighty to eighty-nine percent (80-89%): Total **MRR** is eighty to eighty-nine percent (80-89~~%~~%) or any section (s) is <80%
Not Pass	Below eighty percent (80%)

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i. Any section score of <80% requires a **CAP** for the entire **MRR**, regardless of the total **MRR** score.

j. A non-passing score for a **PCP** site by one health plan shall be considered a non-passing score for all other health plans.

E. Identified Deficiencies and **CAPs**

1. The **CAP** is a standardized, pre-formatted document developed to assist a **PCP** in meeting DHCS requirements. The **CAP** includes the following:

   a. Deficiencies identified through the **FSR** and **MRR** processes;

   b. Corrective action required in order to comply with DHCS standards;

   c. Evidence of correction;

   d. Projected and actual dates of the deficiency correction;

   e. Date correction is implemented;

   f. **PCP** or **Designee** responsible for corrective actions;

   g. Name and title of the Certified Site Reviewer; and

   h. A section for verification of corrections.

2. The **CAP** contains three (3) separate sections:

   a. **FSR**;

   b. Critical elements; and

   c. **MRR**.

3. The **CAP** includes Disclosure and Release statements regarding **CAP** submission timelines and authorization to furnish results of the reviews and corrective actions to other health plans and **Health Networks**.

4. Government agencies that have authority over health plans and authorized county entities in California shall have access to this data.

5. The **CAP** informs the **PCP** that participating health plans collaborated for the **FSR** and **MRR** and agreed to accept the review findings and to furnish to each other the reviews and **CAPs**.

6. CalOptima shall furnish the results of reviews and **CAPs** to the **Health Network** with which the **PCP** site is affiliated.

7. CalOptima shall maintain the signed **FSR CAP** and/or **MRR CAP** in the **PCP** site file. The **CAPs** shall include, at a minimum, the following:

    a. All pages of the **CAP**, with documented deficiencies;

    b. Signed **CAP** face sheet;

    c. Signed attestation; and

    d. Evidence of corrections.

8. CalOptima shall require a **CAP** for a score of less that eighty percent (80%) or for a score of ninety percent (90%) or greater with deficiencies in the areas of critical elements, Pharmaceuticals, or infection control.

9. **CAP** Process

    a. The **Certified Site Reviewer** shall complete the **FSR** and the **MRR**, and shall document the deficiencies on the surveys and the **CAP**.

    b. Upon completion of the review process, the Certified Site Reviewer shall conduct an exit interview with the **PCP** or the **PCP** site contact to discuss the findings and required corrective actions.

    c. The **Certified Site Reviewer** shall instruct the **PCP** or **PCP** site contact that the signature of the **PCP** or **PCP** site contact acknowledges the receipt of the **CAP** and agreement to comply with the designated timeframes for corrective actions as outlined in Section III.E.~~17~~ 16 of this Policy.

10. **PCP** Process for Noting Corrections on the **CAP** Document

    a. The **PCP** or **Designee** shall document the corrective actions taken in the "Corrective Action" required column. The **PCP** or **Designee** shall document the date of implementation of the required corrective actions. Additional steps taken to implement the corrective actions may be documented in this column.

    b. The **PCP** or **Designee** shall initial the appropriate column of the **CAP** to indicate the person responsible for the corrective actions.

    c. The **PCP** or **Designee** shall attach evidence of corrections, such as, but not limited to, applicable policies and procedures, sample forms, invoices for purchased items and services, training in-service agendas, and sign-in sheets.

11. **FSR CAP** Follow-up Process

    a. Verification of correction of identified deficiencies may be accomplished by **PCP** submission of the appropriate evidence of correction.

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b. **CAP** verification may require an on-site visit forty-five (45) calendar days after the date of the review if there is insufficient evidence to determine compliance, or if the deficiency cannot be verified in writing. The **Certified Site Reviewer** shall determine the need for the on-site visit.

12. **MRR CAP** Follow-up Process

    a. The **Certified Site Reviewer** shall determine the process for **CAP** follow-up.

    b. The process may include the following activities:

        i. Score less than eighty percent (80%): On-site visit to verify processes implemented.

        ii. Score between eighty and eight-nine percent (80 – 89%): Documented **CAP** or a **CAP** verification visit and focused record review may be requested at the discretion of the **Certified Site Reviewer**.

        iii. Score ninety to one hundred percent (90 – 100%): Exempted Pass without **CAP**.

13. CalOptima shall monitor the **CAP** until completion. CalOptima shall communicate information regarding a **PCP** Site that shows no improvement, or non-compliance with the required **CAP** activities within the DHCS designated timeframes, to all affiliated **Health Networks**.

14. Review and Acceptance of **CAP**

    a. Following receipt of the completed **CAP**, CalOptima shall evaluate or verify corrections to approve the **CAP**.

    b. CalOptima shall communicate **CAP** approval, in writing, to the **PCP** and his or her assigned CalOptima contracted **Health Network(s)**. CalOptima shall issue a quality Provider Site Certificate to the **PCP** site.

    c. If CalOptima does not accept a **PCP** site's **CAP**, a **Certified Site Reviewer** shall follow-up with the **PCP** for technical assistance, and to ensure compliance with completion of required activities.

15. ~~Pre~~CalOptima shall conduct pre-contractual **PCP** site reviews, and will accept sites with a passing score of eighty percent (80%) or above.

    a. A new **PCP** site that receives a score between eighty and eighty-nine percent (80-89%) (Conditional pass) shall not be considered a **Health Network PCP** until the **PCP** site submits a **CAP** and CalOptima accepts the **CAP**.

    b. A new **PCP** site that receives a score below eighty percent (80%) (Not Pass) shall not be accepted into a **Health Network** ~~until the PCP site submits a CAP and CalOptima verifies and accepts the CAP~~. CalOptima must resurvey the **PCP**, and the **PCP** must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any **CAPs** issued must be completed per **CAP** timeline requirements.

16. CalOptima shall not assign new Members to a PCP with a score below eighty percent (80%) in the FSR or MRR. CalOptima shall resume Member assignment after the PCP completes corrections within the designated time frames and CalOptima closes the CAP.

17. Time F~~f~~rames for **CAP** Activities

    a. At the time of the **FSR** or **MRR**, a Certified Site Reviewer shall notify the **PCP** or **Designee** of the following:

        i. All survey scores, including the non-passing survey scores;

        ii. Deficiencies in the areas of critical elements, Pharmaceuticals Services, or infection control;

        iii. Other deficiencies determined by the Certified Site Reviewer to require immediate corrective action; and

        iv. **CAP** requirements to correct deficiencies.

    b. Within three (3) business days after the survey date, CalOptima shall notify **Health Network** of a **PCP** site that does not meet the passing score of eighty percent (80%) for the **FSR** or the **MRR**.

    c. Within ten (10) business days after the survey date:

        i. The **PCP** or **Designee** shall submit to CalOptima a completed **CAP**, with verification for all critical elements and other deficiencies determined by the reviewer to require immediate corrective action.

        ii. CalOptima shall provide a survey findings report and a formal written request for corrections of all other non-critical element deficiencies to the **PCP**.

        iii. CalOptima shall ensure that sites found deficient in any critical element during a site review shall correct 100% of the deficiencies regardless of the sites' overall survey score.

    d. Within forty-five (45) calendar days after the survey date, CalOptima shall evaluate and verify corrections of all critical elements and other deficiencies, including deficiencies in infection control and pharmaceutical services, determined by the **Certified Site Reviewer** to require immediate corrective action.

    e. Within forty-five (45) calendar days after the date of the written **CAP** request, the **PCP** shall submit to CalOptima a **CAP** for all identified deficiencies, other than critical elements,

        i. If CalOptima does not receive the **CAP** within thirty (30) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** with a reminder that the **CAP** is due in fifteen (15) calendar days.

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ii. CalOptima shall document all contacts with the **PCP** or **Designee** in the **PCP** site file.

f. Within ninety (90) calendar days after the date of the written **CAP** request, CalOptima shall review the submitted **CAP**, and revise and approve the **CAP** and timelines. If additional corrective action is required to complete the **CAP**, the **PCP** shall complete all corrective actions within thirty (30) calendar days.

g. If a **PCP** fails to complete corrections within one-hundred-twenty (120) calendar days after the date of the written **CAP** request:

i. CalOptima shall re-survey the **PCP** site twelve (12) months after the date of the site survey.

ii. CalOptima may impose disciplinary action up to and including administrative termination from CalOptima.

h. CalOptima shall provide the **PCP** with written notification of **Member** reassignment at least ninety (90) calendar days prior to such reassignment.

18. **PCP** Non-Compliance with **CAP** Completion Requirements

a. If a **PCP** submits a **CAP**, but continues to be non-compliant with the **CAP** request, the Certified Site Reviewer shall follow up to provide technical support, in order assist the **PCP** in **CAP** completion.

b. Delayed **CAP** Submission Process:

i. If the **PCP** fails to complete and submit a **CAP** for critical elements, within ten (10) business days after the date of the review, the Certified Site Reviewer shall communicate by telephone with the **PCP** or **Designee**, or send a second and final critical element **CAP** request letter to the **PCP**. If the **PCP** fails to submit required documentation within seventy-two (72) hours after the second (2nd) notice, CalOptima may impose disciplinary action up to and including reassignment of **Members**.

ii. If CalOptima does not receive the **CAP** for non-critical element deficiencies within forty-five (45) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** or **Designee** and request the **CAP** completion within seventy-two (72) hours. If CalOptima does not receive the **CAP** within seventy-two (72) hours, CalOptima shall notify all **Health Networks** and may impose disciplinary action up to and including termination from CalOptima.

iii. CalOptima shall report a **PCP** who fails to submit a **CAP** within the established timelines to the appropriate committee for review and action.

c. CalOptima shall not assign new **Members** to a **PCP** who fails to correct deficiencies within established timelines. If a **PCP** fails to comply with survey criteria within established timelines, CalOptima shall remove the **PCP** from the CalOptima networks and shall appropriately reassign **Members** to other **PCPs**.

d. **PCPs** removed from a contracted **Health Network** may appeal CalOptima's decision in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

F. CalOptima shall review other performance indicators such as **Member** complaints, grievances, and Potential Quality Issues. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** complaints related to physical accessibility or **Member** safety is identified. If any issue related to physical accessibility or **Member** safety then CalOptima shall conduct an unannounced site visit no later than seven (7) calendar days of identification, depending on the severity of the identified patient safety or physical accessibility issue.

~~F.~~G. If the QI Department identifies issues ~~related to the provider site, including~~such as, but not limited to ~~physical accessibility,~~ physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping, then CalOptima shall ~~conduct~~monitor sites and determine when an unannounced ~~site~~ visit~~.~~ is required.

~~1.~~ To identify the need for an unannounced site visit, the QI Department ~~shall review~~monitors Grievance and Appeals Resolution Services (GARS) ~~quarterly activity of~~related to complaints~~.~~

~~2.~~1. ~~CalOptima's QI Department~~ with provider sites. If a provider site receives three (3) or more separate complaints within twelve (12) months, CalOptima shall conduct an unannounced ~~facility site~~ visit ~~within sixty (60) calendar days of the identified Complaint(s).~~.

~~3.~~2. If the standard threshold of eighty percent (80%) is not met upon review, the site will receive a **CAP**.

a. The **CAP** must include how the Provider will address and correct deficiencies.

~~4.~~3. CalOptima's Provider and Health Network Relations Departments, in conjunction with the **FSR** Nurse Auditor, shall collaborate with the Provider site to ensure that the site meets the required threshold of eighty percent (80%).

~~5.~~4. CalOptima shall evaluate deficient sites within forty-five (45) calendar days of the **CAP** issuance until the site meets the threshold score of eighty percent (80%).

~~6.~~5. CalOptima shall conduct a follow-up site visit to evaluate correction of deficiencies, utilizing the Industry Collaborative Effort (ICE) Provider Office Site Quality Site Visit Tool & **CAP**.

a. If deficiencies have not been addressed within sixty (60) calendar days of the unannounced visit or sooner, a physician panel shall be put on hold until deficiencies are resolved.

b. CalOptima shall monitor the facility site every six (6) months following the **CAP** resolution to evaluate the effectiveness of the corrections.

~~G.~~H. Tracking, Reporting, and Trending

1. On a quarterly basis, CalOptima's QI Department shall report a summary of **FSR**, **MRR** and **PARS** activity and action plans to the **CPRC** for monitoring. Reports include assessments, findings, monitoring of previous issues and next steps. **CPRC** will provide quarterly updates to the **CalOptima Quality Improvement Committee (QIC~~.~~)**.

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~~2. CalOptima's QI Department shall conduct a satisfaction survey after on-site reviews and address any issues identified by survey after aggregate analysis and consultation with appropriate committees, such CPRC and QIC.~~

~~3.~~ CalOptima's QI Department shall conduct an annual assessment of the **PARS** process and report findings to the **Credentialing Peer Review Committee (CPRC)** and **CalOptima Quality Improvement Committee (QIC)**.

~~4. On a quarterly basis, CalOptima's QI Department shall report to the QIC the PARS QI Work Plan which will address the following:~~

~~a. Assessments, findings, monitoring of previous issues and next steps; and~~

~~b. Results in the form of metrics along with the next steps.~~

~~5.~~2. Annually the **PARS** process and findings will be reported to the **QIC** as follows:

a. Assessment of completion of planned activities and the objectives of the plan were met;

b. Identification of issues or barriers that impacted meeting the objectives;

c. Recommended interventions to overcome barriers and issues identified;

d. Overall effectiveness of the **PARS** compliance; and

e. Annual assessment of **PARS** process and findings shall be included in CalOptima's annual evaluation.

~~6.~~3. On a monthly basis CalOptima shall notify **Health Networks** of all **FSR**, **MRR**, **PARS** conducted and the scores from the prior month.

~~H.~~I. Review Personnel, Training and Certification

1. **FSR** and **MRR** shall be completed by appropriately trained staff, as outlined in this section.

   a. In accordance with DHCS guidance, **PARS** need not be completed by a Registered Nurse (RN) or physician.

   b. **PARS** shall be completed by appropriately trained CalOptima QI staff.

2. Initial certification: A candidate for certification as a Master Trainer, Trainer, or **Certified Site Reviewer** shall meet the following criteria ~~defined~~ as defined by DHCS.

3. Certification of Managed Care Plan Site Reviewers and Trainers

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Possess current and valid California RN, MD or DO license. Possess current California RN or MD license.	**X**	**X**	**X**
Have experience in training (small groups or individuals) or conducting groups in a health-related field within the past five (5) years; or experience conducting Quality Improvement activities such as medical audits, site reviews, or utilization management activities	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.		**X**	**X**
Completion of a minimum of ten tandem site reviews to include Attachment A and Attachment B criteria and guidelines according to APL 14-004. Knowledge of Facility Site Review Frequently Asked Questions (FAQs). Completion of a minimum of three (3) site reviews according to the 02-002 Site Review Policy and Tools.			**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer.		**X**	
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL 14-004 include Attachment A and Attachment B criteria and guidelines; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of one (1) year as a Trainer/Certified Site Reviewer.	**X**		
Completion of the inter-rater site review process which involves an onsite review with:			
-DHCS MCQMD Nurse Evaluator	**X**		
-Certified Master Trainer		**X**	
-Certified Trainer or Certified Master Trainer			**X**
Achieving an inter-rater score within 10% of **FSR** and 10% of **MRR** ~~Designated Plan~~ Trainer or Master Trainer scores			**X**
Achieving an inter-rater score within 5% of **FSR** and 5% **MRR** of the Master Trainer's scores		**X**	

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Achieving an inter-rater score within 5% of **FSR** and 5% of **MRR** of the DHCS MCQMD Nurse Evaluator	**X**		
Completion and submission of the "Application Request for Certification" to MCQMD (Enclosure A) (Plans have the option to use the application or develop other forms for trainers and reviewers).	**X**		

4. Physicians and RNs designated as Master Trainer, ~~Designated Plan~~ Trainers and **Certified Site Reviewers** will be required to meet the following criteria to maintain their certification.

Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Verification of current and valid California RN, MD or DO license	**X**	**X**	**X**
Must be employed or affiliated with a DHCS Managed Care Plan	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Participate in DHCS MCQMD sponsored site review teleconferences or meetings as defined by the MCQMD Site Review Workgroup	**X**		
Participate in MCQMD sponsored site review training as defined by DHCS	**X**	**X**	**X**
Maintain DHCS certificate number regardless of Health Plan affiliation	**X**		
A new certificate is issued by the primary Managed Care Plan if there is a change in employment		**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

5. A new employee who was previously certified as a Master Trainer, Trainer or **Certified Site Reviewer** by another Medi-Cal Managed Care health plan, but who was not subsequently re-certified, shall meet the following criteria for re-certification by CalOptima:

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Re-Certification Criteria for new employees with lapsed certification	Master Trainer	Trainer	Site Reviewer
Verification of current California RN or MD license	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of certification. Verification of trainers' continued responsibility for training on the MMCD Site Review Policy and Tools and completion of a minimum of five site reviews since initial certification or re-certification	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.	**N/A**	**X**	**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

6. As part of the certification/re-certification process, Master Trainers, ~~Designated Plan~~ Trainers and potential or **Certified Site Reviewers** must complete the inter-rater review (IRR) process. This process requires the Master Trainers, ~~Designated Plan~~ Trainers or **Certified Site Reviewers** to participate in a site review with a designated rater such as the plan Master Trainer or ~~Designated Plan~~ Trainer. Both individuals will concurrently complete and score all elements of the **Facility Site Review** Survey and **Medical Record Review** Survey tools. The Master Trainer, ~~Designated Plan~~ Trainer or **Certified Site Reviewer** must achieve an inter-rater score as defined by DHCS and/or the Site Review Workgroup.

7. Physicians and RNs meeting all ~~of~~ the certification criteria, ~~including~~and achieving an adequate inter-rater score as defined by DHCS, will be certified. All individuals who are certified will receive a certificate issued by DHCS MCQMD or the ~~MCP.~~Medi-Cal Managed Care health Plan. Plans shall follow the instructions for certificate completion. Physicians and RNs who are certified will be authorized to sign site review surveys with the designation of Department of Health Care Services Master Trainer (DHCS-MT), Department of Health Care Services ~~Designated Plan~~ Trainer (DHCS-DPT), or a Department of Health Care Services **Certified Site Reviewer** (DHCS-**CSR**).

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8. If the Master Trainer, ~~Designated Plan~~ Trainer, or **Certified Site Reviewer** ~~does~~has not ~~achieve the~~achieved an adequate inter-rater score defined by DHCS, they may repeat the inter-rater review process. The designated rater and the individual with a non-passing inter-rater score will jointly assess training needs, and develop and implement a training plan prior to conducting a second inter-rater review. Trainers and site reviewers are allowed two (2) opportunities to become certified.

9. One or more of the following may lead to the revocation of certification for the DPT and **CSR** conducting DHCS-approved ~~facility site review and medical record review~~**Facility Site Review** and **Medical Record Review** surveys by CalOptima:

   a. Did not maintain current and valid California RN, MD or DO license;

   b. Resignation, termination, or lack of affiliation from CalOptima;

   c. No participation in the DHCS sponsored inter-rater reliability unless pre-approved by the CalOptima MT or QI Director;

   d. More than two (2) failed ~~facility site review~~**Facility Site Review** survey and/or ~~medical record review~~**Medical Record Review** survey inter-rater reliability scores; and/or

   e. Noncompliance with maintenance of certification criteria.

   f. The above applies to the revocation of MT Certification as determined by DHCS.

10. Assigning Certificate Numbers

    a. A Trainer or **Certified Site Reviewer** shall receive a certificate upon successfully completing the initial and subsequent certification.

    b. CalOptima shall issue certificates to a Trainer or **Certified Site Reviewer**. DHCS shall issue certificates to a Master Trainer.

    c. The certificates shall contain a series of numeric and alpha values to identify the health plan, county, month, and year the certification was granted, and identification code and level of designation for Master Trainer, Trainer, or **Certified Site Reviewer**.

    d. A certificate may be issued in the following format: 000-04-0702-01-A

000	Plan identification Code (CalOptima)
04	Plan Code
0702	Month and Year Certification Granted
01	Plan Trainer or Site Reviewer
A	Master Trainer or Other Trainer
B	Site Reviewer

11. CalOptima shall maintain certification records including, but not limited to, site review training activities and documentation to support the issuance of certificates.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B.A. CalOptima Health Network Service Agreement~~
~~C.A. CalOptima Policy HH.1101: CalOptima Provider Complaint~~
~~D.~~B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health Network Service Agreement
D. CalOptima Policy HH.1101: CalOptima Provider Complaint
E. Department of Health Care Services (DHCS) Policy Letter (PL) 12-006: Revised Facility Site Review Tool
F. Department of Health Care Services (DHCS) Policy Letter (PL) ~~13~~03-002: Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004: Site Reviews: Facility Site Review and Medical Record Review
H. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 14-005: Facility Site Review / Physical-Accessibility Reviews
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-023: Facility Site Review Tools for Ancillary Service and Community-Based Adult Services Providers
J. National Committee for Quality Assurance (NCQA) ~~2017~~2019 Standards: MED ~~4~~3-Practitioner Office Site Quality

VI. REGULATORY AGENCY APPROVALS

A. 04/30/15: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/1996	GG.1608	PCP Site Reviews	Medi-Cal
Revised	01/01/1998	GG.1608	PCP Site Reviews	Medi-Cal
Revised	04/01/1999	GG.1608	PCP Site Reviews	Medi-Cal
Revised	08/01/2000	GG.1608	PCP Site Reviews	Medi-Cal
Revised	10/01/2002	GG.1608	Facility Site Reviews	Medi-Cal
Revised	10/01/2003	GG.1608	Facility Site Reviews	Medi-Cal
Effective	10/01/2005	MA.7011	Practitioner Office Site Reviews	OneCare
Revised	03/01/2007	MA.7011	Full Scope Practitioner Office Site Reviews	OneCare
Revised	04/01/2007	GG.1608	Facility Site Review	Medi-Cal
Revised	09/01/2011	MA.7011	Full Scope Site Reviews	OneCare
Revised	09/01/2011	GG.1608	Full Scope Site Reviews	Medi-Cal

Revised	02/01/2013	GG.1608	Full Scope Site Reviews	Medi-Cal 1 OneCare 2
Revised	12/01/2014	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2015	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2016	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	10/10/2017	GG.1608a	Facility Site Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608b	Medical Record Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608c	Facility Site Review and Medical Record Review Collaboration Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608d	Scoring Process for Facility Site Review and Medical Record Review	Medi-Cal OneCare
Retired	10/10/2017	GG.1608e	Facility Site Review and Medical Record Review Corrective Action Plan	Medi-Cal OneCare
Retired	10/10/2017	GG.1608f	Review Personnel, Training and Certification	Medi-Cal OneCare
Revised	10/01/2017	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2018	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	02/13/2018	MA.7011	Full Scope Site Reviews	OneCare
Revised		GG.1608Δ	Full Scope Site Reviews	OneCare

IX. GLOSSARY

Term	Definition
Ancillary Service Provider Sites	Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services such as radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations
Ancillary Services	For the purposes of this policy, ancillary services refers to diagnostic and therapeutic services such as, but not limited to: radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.
CBAS Providers Sites	CBAS provider sites include all facilities that provide bundled CBAS services, and do not include Licensed Only Adult Day Health Care centers and Programs of All-Inclusive Care for the Elderly (PACE). CBAS services (defined in W&I Code section 14550.5 and provided each day of attendance) include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on the participant's Individual Care Plan.
CBAS Services	For purposes of this policy, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.
Certified Site Reviewer (CSR)	An appropriately qualified and trained physician or registered nurse (RN) who is responsible for conducting provider site reviews, in accordance with DHCS Policy Letter 14-004 and subsequent updates.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as ~~Covered Services~~covered services under CalOptima's 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), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Critical Elements (CE)	Nine critical elements of the site review that defines the potential for adverse effects on patient health and safety, and has a scored weight of two points on the FSR tool.
Designee	For the purposes of this policy, a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role, as determined by CalOptima QI staff.
Facility Site Review (FSR) Survey	A DHCS tool utilized to assess the quality, safety, and accessibility of PCPs and high-volume specialists physician offices.
Full Scope Site Review	For the purposes of this policy, means a comprehensive site review as required by DHCS guidelines which encompass a Facility Site Review (FSR) and Medical Record Review (MRR) of a Primary Care Provider (PCP) site.
Health Network	A Physician Hospital Consortium (PHC~~), Physician Medical Group (PMG~~), a 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~~covered services to Members assigned to that Health Network.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Medical Record	For the purposes of this policy, 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.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including high volume specialists, CBAS and ancillary service providers.
Potential Quality Issues (PQIs)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised.

Term	Definition
Primary Care Provider (PCP)	For the purposes of this policy, a primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

Policy #:	GG.1608Δ
Title:	**Full Scope Site Reviews**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/96
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy outlines CalOptima's site review process, including the **Facility Site Review (FSR)**, **Medical Record Review (MRR)**, and **Physical Accessibility Review Survey (PARS)**, and the process by which CalOptima conducts, scores, tracks, and reports site reviews in accordance with applicable state and federal guidelines.

II. POLICY

A. CalOptima shall assess the quality, safety, and accessibility of sites where care is delivered in accordance with Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS) guidelines and regulations.

B. CalOptima may delegate **FSR**, **MRR**, and **PARS** to a Knox-Keene licensed full service health care service plan that is contracted with CalOptima as a **Health Network**. Such delegated health plan shall conduct **FSR**, **MRR**, and **PARS** in accordance with the provisions of this Policy and in compliance with applicable DHCS and CMS guidelines and regulations.

C. CalOptima shall retain responsibility and accountability for the coordination and consolidation of **FSR**, **MRR**, or **PARS** and shall not delegate such reviews to a **Health Network**, except where CalOptima approves a delegation to a full service Knox-Keene licensed **Health Maintenance Organization (HMO)** in accordance with Section II.B of this Policy.

D. CalOptima's Quality Improvement (QI) Department shall conduct **FSR**, **MRR**, and **PARS**, as well as subsequent periodic site reviews, as part of the initial **credentialing** and recredentialing process, regardless of the status of other certification or accreditation, if:

1. There is no documented evidence that the **Primary Care Provider (PCP)** site has a current passing score on a survey conducted by another Medi-Cal Managed Care health plan; or

2. A **PCP** from a certified **PCP** site moves to a new site that has not been previously reviewed.

E. A Full Scope/Periodic Site Review consists of the **FSR** and **MRR**.

1. CalOptima is not required to conduct a **Full Scope Site Review** for a **PCP** site if a new **PCP** is added to a **PCP** site that has a current passing **Full Scope Site Review** score.

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F. **Full** Scope Site Reviews shall be conducted by specified CalOptima staff as outlined in Section III.A of this Policy.

G. CalOptima's QI Department shall conduct a **FSR** for new **PCP** sites that have never received a **FSR** or have not had a passing review in the past three (3) years.

H. CalOptima's QI Department shall conduct a **MRR survey** for new **PCP** sites within ninety (90) calendar days of the date CalOptima first assigns **Members** to the **PCP.** CalOptima may defer the review an additional ninety (90) calendar days only if the new **PCP** does not have a sufficient number of **Members assigned** to complete a review of ten (10) **Medical Records.** At the end of six (6) months, if the **PCP** still has fewer than ten (10) assigned **Member Medical Records,** CalOptima must complete an MRR on the total number of records available, and adjust the scoring according to the number of records reviewed.

I. CalOptima's QI Department shall conduct a **PARS** at the time of initial **credentialing** for the following:

1. All **PCP** offices;

2. **Specialty Care Provider** offices, **Community Based Adult Services (CBAS) Provider Sites**, and **Ancillary Service Provider Sites** serving a high volume of **Seniors and Persons with Disabilities (SPD)**; and

3. **Specialty Care Provider** offices and **Ancillary Service Provider Sites** included in the provider directory who are serving a high volume of OneCare Connect **Members**.

J. CalOptima shall conduct a subsequent **FSR**, **MRR**, and **PARS** of a **PCP** site at least every three (3) years.

1. CalOptima may waive an **FSR**, **MRR**, and/or **PARS** for a pre-contracted **PCP** site if the **PCP** site has documented proof that an **FSR**, **MRR**, and/or **PARS** with a passing score was completed by a Medi-Cal Managed Care health plan within the past three (3) years.

2. CalOptima may conduct an **FSR**, **MRR**, and/or **PARS** more frequently if required by local collaborative decision, or if CalOptima determines that it is necessary based on monitoring, evaluation, or **Corrective Action Plan (CAP)** follow-up issues.

K. CalOptima shall monitor a **PCP** site between each regularly scheduled **FSR**.

1. CalOptima shall conduct an interim audit midcycle (approximately eighteen (18) months) after the previous audit date to evaluate the nine (9) Critical Elements from the **FSR**.

a. If there was no **Critical Element CAP** received during the previous audit, the office will receive an attestation to sign and return to CalOptima attesting all Critical Elements are in effect.

b. If the **Critical Elements CAP** was received during the previous audit, an on-site audit will be conducted on the **Critical Elements** only.

L. CalOptima's QI Department shall score the **FSR**, **MRR**, and **PARS** in accordance with Section III.D of this Policy.

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M. CalOptima's QI Department shall identify deficiencies and request **Corrective Action Plans (CAP)** for **FSR** and **MRR** deficiencies, in accordance with Section III.E of this Policy.

1. **CAPs** will not be issued for **PARS** results, as these results are informational.

2. CalOptima shall document **PARS** results and make survey records available to DHCS for review upon request.

N. **Members** shall not receive **Covered Services** at a new **PCP** site until the site receives a passing **FSR** score, as outlined in Section III.D.1 of this Policy, and/or completes required **CAPs** issued by CalOptima's QI Department.

O. Notwithstanding the corrective action time requirements set forth in this Policy, CalOptima shall not allow an existing **PCP** site with major or serious uncorrected deficiencies to continue providing care to **Members** until the site corrects all such deficiencies.

P. All **Health Networks** shall accept CalOptima site review surveys status or results to coordinate and consolidate site audits for shared **PCPs**.

Q. A **PCP** shall notify CalOptima when the **PCP** intends to relocate its practice at least thirty (30) calendar days prior to the relocation. Upon notification of the relocation, CalOptima shall conduct an **FSR**, **MRR**, and **PARS** on the new location, except as described in Section II.E.1 of this Policy.

1. If a PCP notifies CalOptima after the move:

   a. CalOptima will permit assigned **Members** to continue to see the PCP;

   b. CalOptima will not assign new **Members** to the PCP until CalOptima conducts an **FSR** on the new location; and

   c. CalOptima will complete an **FSR** on the new location within thirty (30) calendar days of the notification of the move.

R. The site review process described in this policy shall remain confidential and protected from disclosure in accordance with applicable law.

S. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** Complaints related to physical accessibility or **Member** safety, pursuant to Section III.F of this Policy, are filed with CalOptima's QI Department.

T. CalOptima may collect additional information at **PCP** sites during the **FSR** process, including but not limited to, information on member experience, and timely access to **Covered Services**.

III. PROCEDURE

A. **Facility Site Review:**

1. The **FSR** includes on-site inspection and interviews with site personnel to review criteria outlined by DHCS including, but not limited to, the following nine (9) **Critical Elements** that may adversely affect a **Member's** health or safety:

   a. Exit doors and aisles are unobstructed and escape accessible;

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b. Airway management equipment is appropriate to the practice and populations served (e.g., oxygen delivery systems, oral airways, nasal canula or mask, Ambu bag) and are present on site;

c. Only qualified and trained personnel retrieve, prepare, or administer medications;

d. The Physician must review and follow-up with referrals, consultation reports and diagnostic test results;

e. Only lawfully authorized persons dispense drugs to patients;

f. Personal Protective Equipment (PPE) is readily available for staff use;

g. Needlestick safety precautions are practiced on site;

h. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, and shipping; and

i. Spore testing of autoclave or steam sterilizer is completed at least monthly with documented results.

B. **Medical Record Review:**

1. CalOptima may conduct the **MRR** at the same time as the **FSR**, or at another mutually agreed-upon time.

a. CalOptima shall conduct an initial **MRR** within ninety (90) calendar days after the first (1st) day **Members** are assigned to the **PCP**, except if the **PCP** has a "shared" **Medical Records** system, as described in Section III.B.2.b of this Policy.

b. CalOptima may grant an extension of ninety (90) calendar days if the new **PCP** does not have a sufficient number of **Members** assigned to complete a review of ten (10) **Medical Records**.

c. If, at six (6) months after the first (1st) day **Members** are assigned to the **PCP**, the **PCP** still has fewer than ten (10) assigned **Member Medical Records**, CalOptima shall conduct a **MRR** of all available **Member Medical Records**.

d. CalOptima shall adjust the scoring of the **MRR** according to the number of records reviewed.

2. **Medical Record** selection

a. Individual PCP Medical Record system

i. The **MRR** is based on a survey standard of ten (10) randomly selected **Medical Records** per **PCP**, consisting of five (5) pediatric and five (5) adult and/adults or obstetric (OB) records.

ii. If a **PCP** site has only pediatric, only adult, or only obstetric patients, CalOptima shall conduct the **MRR** on ten (10) records in the preventive care area relevant to the **Member** population served at the **PCP** site.

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iii. Prior to initiating the **MRR**, a **Certified Site Reviewer** shall determine the **Member** populations (adult, pediatric, OB/Comprehensive Perinatal Services Program (CPSP)) served by the **PCP** site, and shall determine the **Medical Records** and audit tools appropriate for the **PCP** site.

b. Shared PCP Medical Record system

i. CalOptima shall consider a **PCP** site where documentation of patient care by multiple **PCPs** occurs in the same medical record as a "shared" **Medical Records** system. Shared **Medical Records** shall be considered those that are not identifiable as separate records belonging to any specific **PCP**.

ii. If a new **PCP** joins a **PCP** site that uses a shared **Medical Records** system that has a current passing **MRR** Survey score, CalOptima shall review the new **PCP** according to the periodic review cycle of the **PCP** site.

iii. CalOptima shall select **Medical Records** by random selection, using every other **Medical Record**, as follows:

Number of PCPs at the site	Number of Medical Records to be pulled by the staff	Number of Medical Records to be randomly selected and reviewed
1-3	10-20	10
4-6	20-40	20
7 or greater	30-60	30

a) CalOptima shall select **Medical Records** randomly from all **PCPs** at the site.

b) CalOptima shall select **Medical Records** for CalOptima **Members** only.

c) CalOptima prefers that each **Medical Record** include at least three (3) visits within the twelve (12) months preceding the date of review.

C. **Physical Accessibility Review Survey:**

1. The **PARS** for **PCP** and Specialist sites shall evaluate access for **Members** with disabilities to parking, building, elevator, and restroom facilities. It includes twenty-nine (29) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

2. The **PARS** for **ancillary provider sites** shall evaluate ancillary facility site access for **Members** with disabilities to parking, building, elevator, restrooms, diagnostic and treatment room/equipment use. It includes thirty-four (34) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

3. The **PARS** for **CBAS provider sites** evaluate facility site access for **Members** with disabilities to parking, building, elevator, participant areas, and restrooms. It includes twenty-four (24) critical elements, all of which must be met for the site to satisfy Basic Access requirements.

4. Scoring of the **PARS**:

a. Physical accessibility shall be determined as Basic or Limited based on the type of site assessment.

b. To meet Basic Access requirements, all critical elements found in the **PARS** specific to the provider site must be met.

c. **PCPs**, as well as **Specialty Care Providers**, **Ancillary Service**, and **CBAS** Provider **sites** serving a high volume of **SPD** and OneCare Connect **Members** will receive a deficiency and be classified as Limited Access if one (1) or more of the critical elements of the **PAR Survey** are not met.

5. **PARS** Deficiencies Process:

a. If deficiencies in one (1) or more of the critical elements are identified, the facility site shall be deemed Limited Access, in accordance with the **PARS**.

i. CalOptima shall provide a record of deficiencies to the office receiving the **PARS** to maintain compliance with the Americans with Disabilities Act (ADA).

a) The reviewer will summarize the list of deficiencies and discuss all deficiencies at the exit interview with the **PCP** and will send a summary of deficiencies to the facility manager within forty-five (45) calendar days of the review.

ii. The office must address all deficiencies and provide reasons why deficiencies will not be corrected to meet ADA requirements.

a) The **PCP** or facility manager shall respond to CalOptima within thirty (30) calendar days of the **PARS** review for how deficiencies will be addressed, including the timeframe and activities for correcting identified deficiencies.

iii. If major construction deficiencies are identified, the office must have the property management company provide a written statement, on their business letterhead, as to why the deficiency cannot be corrected.

iv. Upon receipt of the letter, it will be filed with the **FSR** folder and reported to DHCS upon request.

v. If the deficiencies are minor and within reason to correct and the provider refuses to make the corrections the issue will be taken to **Credentialing and Peer Review Committee (CPRC)** for discussion and a decision.

6. CalOptima shall publish physical accessibility indicators including, but not limited to, level of access results met per provider site as either Basic Access or Limited Access, in the Provider Directory and Web-based Directory.

D. **Facility Site Review** and **Medical Record Review** Survey Scoring

1. Scoring of the **FSR** and **MRR**:

a. **FSR** and **MRR** shall only be completed and scored by designated personnel, in accordance with Section III.I of this Policy.

b. To pass a **Full Scope Site Review**, a **PCP** site shall achieve a minimum score of eighty percent (80%) on both the **FSR** and the **MRR**.

i. CalOptima shall not average the **FSR** and the **MRR** scores.

ii. A score below eighty percent (80%) on either the **FSR** or **MRR** shall be considered a non-passing **Full Scope Site Review** score.

c. CalOptima shall award only full point value for any scored element on the **FSR** or **MRR**. CalOptima shall not award any partial points.

i. If an element does not fully meet criteria, the **Certified Site Reviewer** shall give a score of zero (0) for that element.

ii. The **Certified Site Reviewer** shall determine the "not applicable" status of a criterion based on the relevance to the **Member** population served at the **PCP** site, and the site-specific assessment.

iii. The **Certified Site Reviewer** shall document a written explanation for every score of zero (0) points, and every criterion determined as "not applicable".

d. After completing the **FSR** and **MRR**, the **Certified Site Reviewer** shall calculate the **PCP** site score in each survey to determine the compliance rate and the need for follow-up.

e. The minimum passing score for the **FSR** is eighty percent (80%) of the total points available. A **PCP** site may earn up to one hundred fifty (150) points for a site review with the following compliance level categories:

Compliance Categories	**Compliance Rate**
Exempted Pass	Ninety percent (90%) or above without deficiencies in critical elements, pharmaceutical services, or infection control
Conditional Pass	Eighty to eighty-nine percent (80-89%); or Ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control
Not Pass	Below eighty percent (80%)

f. N/A applies to any scored item that does not apply to a specific site, as determined by the Certified Site Reviewer.

g. The **MRR** contains three (3) general categories of Format, Documentation, and Coordination/Continuity of Care, and three (3) specific preventive categories of Pediatric Preventive, Adult Preventive, and OB/CPSP. **PCP** sites may earn up to twenty-three (23) points for the three (3) general categories multiplied by the number of **Medical Records** reviewed, plus the points given for the preventive services categories, as follows:

i. Pediatric Preventive: Nineteen (19) points multiplied by the number of pediatric **Medical Records** reviewed;

ii. Adult Preventive: Fifteen (15) points multiplied by the number of adult **Medical Records** reviewed; and

iii. OB/CPSP: Twenty (20) points multiplied by the number of OB/CPSP **Medical Records** reviewed.

h. The **MRR** compliance levels are as follows:

Compliance Categories	Compliance Rate
Exempted Pass	Ninety percent (90%) or above: Total score is >90% and all section scores are eighty percent (80%) or above
Conditional Pass	Eighty to eighty-nine percent (80-89%): Total **MRR** is eighty to eighty-nine percent (80-89%) or any section (s) is <80%
Not Pass	Below eighty percent (80%)

i. Any section score of <80% requires a **CAP** for the entire **MRR**, regardless of the total **MRR** score.

j. A non-passing score for a **PCP** site by one health plan shall be considered a non-passing score for all other health plans.

E. Identified Deficiencies and **CAPs**

1. The **CAP** is a standardized, pre-formatted document developed to assist a **PCP** in meeting DHCS requirements. The **CAP** includes the following:

   a. Deficiencies identified through the **FSR** and **MRR** processes;

   b. Corrective action required in order to comply with DHCS standards;

   c. Evidence of correction;

   d. Projected and actual dates of the deficiency correction;

   e. Date correction is implemented;

   f. **PCP** or **Designee** responsible for corrective actions;

   g. Name and title of the Certified Site Reviewer; and

   h. A section for verification of corrections.

2. The **CAP** contains three (3) separate sections:

   a. **FSR**;

   b. Critical elements; and

   c. **MRR**.

3. The **CAP** includes Disclosure and Release statements regarding **CAP** submission timelines and authorization to furnish results of the reviews and corrective actions to other health plans and **Health Networks**.

4. Government agencies that have authority over health plans and authorized county entities in California shall have access to this data.

5. The **CAP** informs the **PCP** that participating health plans collaborated for the **FSR** and **MRR** and agreed to accept the review findings and to furnish to each other the reviews and **CAPs**.

6. CalOptima shall furnish the results of reviews and **CAPs** to the **Health Network** with which the **PCP** site is affiliated.

7. CalOptima shall maintain the signed **FSR CAP** and/or **MRR CAP** in the **PCP** site file. The **CAPs** shall include, at a minimum, the following:

    a. All pages of the **CAP**, with documented deficiencies;

    b. Signed **CAP** face sheet;

    c. Signed attestation; and

    d. Evidence of corrections.

8. CalOptima shall require a **CAP** for a score of less that eighty percent (80%) or for a score of ninety percent (90%) or greater with deficiencies in the areas of critical elements, Pharmaceuticals, or infection control.

9. **CAP** Process

    a. The **Certified Site Reviewer** shall complete the **FSR** and the **MRR**, and shall document the deficiencies on the surveys and the **CAP**.

    b. Upon completion of the review process, the Certified Site Reviewer shall conduct an exit interview with the **PCP** or the **PCP** site contact to discuss the findings and required corrective actions.

    c. The **Certified Site Reviewer** shall instruct the **PCP** or **PCP** site contact that the signature of the **PCP** or **PCP** site contact acknowledges the receipt of the **CAP** and agreement to comply with the designated timeframes for corrective actions as outlined in Section III.E.16 of this Policy.

10. **PCP** Process for Noting Corrections on the **CAP** Document

    a. The **PCP** or **Designee** shall document the corrective actions taken in the "Corrective Action" required column. The **PCP** or **Designee** shall document the date of implementation of the required corrective actions. Additional steps taken to implement the corrective actions may be documented in this column.

    b. The **PCP** or **Designee** shall initial the appropriate column of the **CAP** to indicate the person responsible for the corrective actions.

    c. The **PCP** or **Designee** shall attach evidence of corrections, such as, but not limited to, applicable policies and procedures, sample forms, invoices for purchased items and services, training in-service agendas, and sign-in sheets.

11. **FSR CAP** Follow-up Process

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a. Verification of correction of identified deficiencies may be accomplished by **PCP** submission of the appropriate evidence of correction.

b. **CAP** verification may require an on-site visit forty-five (45) calendar days after the date of the review if there is insufficient evidence to determine compliance, or if the deficiency cannot be verified in writing. The **Certified Site Reviewer** shall determine the need for the on-site visit.

12. **MRR CAP** Follow-up Process

    a. The **Certified Site Reviewer** shall determine the process for **CAP** follow-up.

    b. The process may include the following activities:

        i. Score less than eighty percent (80%): On-site visit to verify processes implemented.

        ii. Score between eighty and eight-nine percent (80 – 89%): Documented **CAP** or a **CAP** verification visit and focused record review may be requested at the discretion of the **Certified Site Reviewer**.

        iii. Score ninety to one hundred percent (90 – 100%): Exempted Pass without **CAP**.

13. CalOptima shall monitor the **CAP** until completion. CalOptima shall communicate information regarding a **PCP** Site that shows no improvement, or non-compliance with the required **CAP** activities within the DHCS designated timeframes, to all affiliated **Health Networks**.

14. Review and Acceptance of **CAP**

    a. Following receipt of the completed **CAP**, CalOptima shall evaluate or verify corrections to approve the **CAP**.

    b. CalOptima shall communicate **CAP** approval, in writing, to the **PCP** and his or her assigned CalOptima contracted **Health Network(s)**. CalOptima shall issue a quality Provider Site Certificate to the **PCP** site.

    c. If CalOptima does not accept a **PCP** site's **CAP**, a **Certified Site Reviewer** shall follow-up with the **PCP** for technical assistance, and to ensure compliance with completion of required activities.

15. CalOptima shall conduct pre-contractual **PCP** site reviews, and will accept sites with a passing score of eighty percent (80%) or above.

    a. A new **PCP** site that receives a score between eighty and eighty-nine percent (80-89%) (Conditional pass) shall not be considered a **Health Network PCP** until the **PCP** site submits a **CAP** and CalOptima accepts the **CAP**.

    b. A new **PCP** site that receives a score below eighty percent (80%) (Not Pass) shall not be accepted into a **Health Network**. CalOptima must resurvey the **PCP**, and the **PCP** must pass with at least a score of eighty percent (80%) to be considered a CalOptima network provider. Any **CAPs** issued must be completed per **CAP** timeline requirements.

16. CalOptima shall not assign new Members to a PCP with a score below eighty percent (80%) in the FSR or MRR. CalOptima shall resume Member assignment after the PCP completes corrections within the designated time frames and CalOptima closes the CAP.

17. Time Frames for **CAP** Activities

    a. At the time of the **FSR** or **MRR**, a Certified Site Reviewer shall notify the **PCP** or **Designee** of the following:

        i. All survey scores, including the non-passing survey scores;

        ii. Deficiencies in the areas of critical elements, Pharmaceuticals Services, or infection control;

        iii. Other deficiencies determined by the Certified Site Reviewer to require immediate corrective action; and

        iv. **CAP** requirements to correct deficiencies.

    b. Within three (3) business days after the survey date, CalOptima shall notify **Health Network** of a **PCP** site that does not meet the passing score of eighty percent (80%) for the **FSR** or the **MRR**.

    c. Within ten (10) business days after the survey date:

        i. The **PCP** or **Designee** shall submit to CalOptima a completed **CAP**, with verification for all critical elements and other deficiencies determined by the reviewer to require immediate corrective action.

        ii. CalOptima shall provide a survey findings report and a formal written request for corrections of all other non-critical element deficiencies to the **PCP**.

        iii. CalOptima shall ensure that sites found deficient in any critical element during a site review shall correct 100% of the deficiencies regardless of the sites' overall survey score.

    d. Within forty-five (45) calendar days after the survey date, CalOptima shall evaluate and verify corrections of all critical elements and other deficiencies, including deficiencies in infection control and pharmaceutical services, determined by the **Certified Site Reviewer** to require immediate corrective action.

    e. Within forty-five (45) calendar days after the date of the written **CAP** request, the **PCP** shall submit to CalOptima a **CAP** for all identified deficiencies, other than critical elements,

        i. If CalOptima does not receive the **CAP** within thirty (30) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** with a reminder that the **CAP** is due in fifteen (15) calendar days.

        ii. CalOptima shall document all contacts with the **PCP** or **Designee** in the **PCP** site file.

    f. Within ninety (90) calendar days after the date of the written **CAP** request, CalOptima shall review the submitted **CAP**, and revise and approve the **CAP** and timelines. If additional

corrective action is required to complete the **CAP**, the **PCP** shall complete all corrective actions within thirty (30) calendar days.

g. If a **PCP** fails to complete corrections within one-hundred-twenty (120) calendar days after the date of the written **CAP** request:

i. CalOptima shall re-survey the **PCP** site twelve (12) months after the date of the site survey.

ii. CalOptima may impose disciplinary action up to and including administrative termination from CalOptima.

h. CalOptima shall provide the **PCP** with written notification of **Member** reassignment at least ninety (90) calendar days prior to such reassignment.

18. **PCP** Non-Compliance with **CAP** Completion Requirements

a. If a **PCP** submits a **CAP**, but continues to be non-compliant with the **CAP** request, the Certified Site Reviewer shall follow up to provide technical support, in order assist the **PCP** in **CAP** completion.

b. Delayed **CAP** Submission Process:

i. If the **PCP** fails to complete and submit a **CAP** for critical elements, within ten (10) business days after the date of the review, the Certified Site Reviewer shall communicate by telephone with the **PCP** or **Designee**, or send a second and final critical element **CAP** request letter to the **PCP**. If the **PCP** fails to submit required documentation within seventy-two (72) hours after the second (2nd) notice, CalOptima may impose disciplinary action up to and including reassignment of **Members**.

ii. If CalOptima does not receive the **CAP** for non-critical element deficiencies within forty-five (45) calendar days after the date of the **CAP** request, CalOptima shall contact the **PCP** or **Designee** and request the **CAP** completion within seventy-two (72) hours. If CalOptima does not receive the **CAP** within seventy-two (72) hours, CalOptima shall notify all **Health Networks** and may impose disciplinary action up to and including termination from CalOptima.

iii. CalOptima shall report a **PCP** who fails to submit a **CAP** within the established timelines to the appropriate committee for review and action.

c. CalOptima shall not assign new **Members** to a **PCP** who fails to correct deficiencies within established timelines. If a **PCP** fails to comply with survey criteria within established timelines, CalOptima shall remove the **PCP** from the CalOptima networks and shall appropriately reassign **Members** to other **PCPs**.

d. **PCPs** removed from a contracted **Health Network** may appeal CalOptima's decision in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

F. CalOptima shall review other performance indicators such as **Member** complaints, grievances, and Potential Quality Issues. CalOptima shall conduct an unannounced site visit of offices when one (1) or more **Member** complaints related to physical accessibility or **Member** safety is identified. If any issue related to physical accessibility or **Member** safety then CalOptima shall conduct an

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unannounced site visit no later than seven (7) calendar days of identification, depending on the severity of the identified patient safety or physical accessibility issue.

G. If the QI Department identifies issues such as, but not limited to physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping, then CalOptima shall monitor sites and determine when an unannounced visit is required.

1. To identify the need for an unannounced site visit, the QI Department monitors Grievance and Appeals Resolution Services (GARS) related to complaints with provider sites. If a provider site receives three (3) or more separate complaints within twelve (12) months, CalOptima shall conduct an unannounced visit.

2. If the standard threshold of eighty percent (80%) is not met upon review, the site will receive a **CAP**.

   a. The **CAP** must include how the Provider will address and correct deficiencies.

3. CalOptima's Provider and Health Network Relations Departments, in conjunction with the **FSR** Nurse Auditor, shall collaborate with the Provider site to ensure that the site meets the required threshold of eighty percent (80%).

4. CalOptima shall evaluate deficient sites within forty-five (45) calendar days of the **CAP** issuance until the site meets the threshold score of eighty percent (80%).

5. CalOptima shall conduct a follow-up site visit to evaluate correction of deficiencies, utilizing the Industry Collaborative Effort (ICE) Provider Office Site Quality Site Visit Tool & **CAP**.

   a. If deficiencies have not been addressed within sixty (60) calendar days of the unannounced visit or sooner, a physician panel shall be put on hold until deficiencies are resolved.

   b. CalOptima shall monitor the facility site every six (6) months following the **CAP** resolution to evaluate the effectiveness of the corrections.

H. Tracking, Reporting, and Trending

1. On a quarterly basis, CalOptima's QI Department shall report a summary of **FSR**, **MRR** and **PARS** activity and action plans to the **CPRC** for monitoring. Reports include assessments, findings, monitoring of previous issues and next steps. **CPRC** will provide quarterly updates to the **CalOptima Quality Improvement Committee (QIC)**.

2. CalOptima's QI Department shall conduct an annual assessment of the **PARS** process and report findings to the **Credentialing Peer Review Committee (CPRC)** and **CalOptima Quality Improvement Committee (QIC)**. Annually the **PARS** process and findings will be reported to the **QIC** as follows:

   a. Assessment of completion of planned activities and the objectives of the plan were met;

   b. Identification of issues or barriers that impacted meeting the objectives;

   c. Recommended interventions to overcome barriers and issues identified;

d. Overall effectiveness of the **PARS** compliance; and

e. Annual assessment of **PARS** process and findings shall be included in CalOptima's annual evaluation.

3. On a monthly basis CalOptima shall notify **Health Networks** of all **FSR**, **MRR**, **PARS** conducted and the scores from the prior month.

I. Review Personnel, Training and Certification

1. **FSR** and **MRR** shall be completed by appropriately trained staff, as outlined in this section.

a. In accordance with DHCS guidance, **PARS** need not be completed by a Registered Nurse (RN) or physician.

b. **PARS** shall be completed by appropriately trained CalOptima QI staff.

2. Initial certification: A candidate for certification as a Master Trainer, Trainer, or **Certified Site Reviewer** shall meet the following criteria as defined by DHCS.

3. Certification of Managed Care Plan Site Reviewers and Trainers

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Possess current and valid California RN, MD or DO license. Possess current California RN or MD license.	**X**	**X**	**X**
Have experience in training (small groups or individuals) or conducting groups in a health-related field within the past five (5) years; or experience conducting Quality Improvement activities such as medical audits, site reviews, or utilization management activities	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.		**X**	**X**
Completion of a minimum of ten tandem site reviews to include Attachment A and Attachment B criteria and guidelines according to APL 14-004. Knowledge of Facility Site Review Frequently Asked Questions (FAQs). Completion of a minimum of three (3) site reviews according to the 02-002 Site Review Policy and Tools.			**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer.		**X**	

Initial Certification Criteria	Master Trainer	Trainer	Site Reviewer
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL 14-004 include Attachment A and Attachment B criteria and guidelines; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of one (1) year as a Trainer/Certified Site Reviewer.	**X**		
Completion of the inter-rater site review process which involves an onsite review with:			
-DHCS MCQMD Nurse Evaluator	**X**		
-Certified Master Trainer		**X**	
-Certified Trainer or Certified Master Trainer			**X**
Achieving an inter-rater score within 10% of **FSR** and 10% of **MRR** Trainer or Master Trainer scores			**X**
Achieving an inter-rater score within 5% of **FSR** and 5% **MRR** of the Master Trainer's scores		**X**	
Achieving an inter-rater score within 5% of **FSR** and 5% of **MRR** of the DHCS MCQMD Nurse Evaluator	**X**		
Completion and submission of the "Application Request for Certification" to MCQMD (Enclosure A) (Plans have the option to use the application or develop other forms for trainers and reviewers).	**X**		

4. Physicians and RNs designated as Master Trainer, Trainers and **Certified Site Reviewers** will be required to meet the following criteria to maintain their certification.

Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Verification of current and valid California RN, MD or DO license	**X**	**X**	**X**
Must be employed or affiliated with a DHCS Managed Care Plan	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Participate in DHCS MCQMD sponsored site review teleconferences or meetings as defined by the MCQMD Site Review Workgroup	**X**		
Participate in MCQMD sponsored site review training as defined by DHCS	**X**	**X**	**X**

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Re-Certification Criteria	Master Trainer	Trainer	Site Reviewer
Maintain DHCS certificate number regardless of Health Plan affiliation	**X**		
A new certificate is issued by the primary Managed Care Plan if there is a change in employment		**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

5. A new employee who was previously certified as a Master Trainer, Trainer or **Certified Site Reviewer** by another Medi-Cal Managed Care health plan, but who was not subsequently re-certified, shall meet the following criteria for re-certification by CalOptima:

Re-Certification Criteria for new employees with lapsed certification	Master Trainer	Trainer	Site Reviewer
Verification of current California RN or MD license	**X**	**X**	**X**
Verification of trainers' continued responsibility for training on the DHCS MCQMD Site Review Policy; tools and completion of a minimum of ten site reviews every three-year cycle since the issue date of certification. Verification of trainers' continued responsibility for training on the MMCD Site Review Policy and Tools and completion of a minimum of five site reviews since initial certification or re-certification	**X**	**X**	
Attend didactic site review training(s) sponsored by DHCS or completion of the DHCS didactic site review training modules with a Master Trainer.	**N/A**	**X**	**X**
Completion of a minimum of ten site reviews to include Attachment A and Attachment B criteria and guidelines; Knowledge of APL14-004; Knowledge of Facility Site Review Frequently Asked Questions (FAQs); and a minimum of six (6) months as a Certified Site Reviewer	**X**	**X**	
Completion of a minimum of ten site reviews every three-year cycle since the issue date of certification			**X**
Participate in plan-sponsored site review training sessions	**X**	**X**	**X**
Completion of the inter-rater medical record review process and achieve an inter-rater score of 10% variance as defined by the DHCS MCQMD Site Review Workgroup	**X**	**X**	**X**

6. As part of the certification/re-certification process, Master Trainers, Trainers and potential or **Certified Site Reviewers** must complete the inter-rater review (IRR) process. This process requires the Master Trainers, Trainers or **Certified Site Reviewers** to participate in a site

review with a designated rater such as the plan Master Trainer or Trainer. Both individuals will concurrently complete and score all elements of the **Facility Site Review** Survey and **Medical Record Review** Survey tools. The Master Trainer, Trainer or **Certified Site Reviewer** must achieve an inter-rater score as defined by DHCS and/or the Site Review Workgroup.

7. Physicians and RNs meeting all the certification criteria, and achieving an adequate inter-rater score as defined by DHCS, will be certified. All individuals who are certified will receive a certificate issued by DHCS MCQMD or the Medi-Cal Managed Care health Plan. Plans shall follow the instructions for certificate completion. Physicians and RNs who are certified will be authorized to sign site review surveys with the designation of Department of Health Care Services Master Trainer (DHCS-MT), Department of Health Care Services Trainer (DHCS-DPT), or a Department of Health Care Services **Certified Site Reviewer** (DHCS-**CSR**).

8. If the Master Trainer, Trainer, or **Certified Site Reviewer** has not achieved an adequate inter-rater score defined by DHCS, they may repeat the inter-rater review process. The designated rater and the individual with a non-passing inter-rater score will jointly assess training needs, and develop and implement a training plan prior to conducting a second inter-rater review. Trainers and site reviewers are allowed two (2) opportunities to become certified.

9. One or more of the following may lead to the revocation of certification for the DPT and **CSR** conducting DHCS-approved **Facility Site Review** and **Medical Record Review** surveys by CalOptima:

    a. Did not maintain current and valid California RN, MD or DO license;

    b. Resignation, termination, or lack of affiliation from CalOptima;

    c. No participation in the DHCS sponsored inter-rater reliability unless pre-approved by the CalOptima MT or QI Director;

    d. More than two (2) failed **Facility Site Review** survey and/or **Medical Record Review** survey inter-rater reliability scores; and/or

    e. Noncompliance with maintenance of certification criteria.

    f. The above applies to the revocation of MT Certification as determined by DHCS.

10. Assigning Certificate Numbers

    a. A Trainer or **Certified Site Reviewer** shall receive a certificate upon successfully completing the initial and subsequent certification.

    b. CalOptima shall issue certificates to a Trainer or **Certified Site Reviewer**. DHCS shall issue certificates to a Master Trainer.

    c. The certificates shall contain a series of numeric and alpha values to identify the health plan, county, month, and year the certification was granted, and identification code and level of designation for Master Trainer, Trainer, or **Certified Site Reviewer**.

    d. A certificate may be issued in the following format: 000-04-0702-01-A

000	Plan identification Code (CalOptima)

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04	Plan Code
0702	Month and Year Certification Granted
01	Plan Trainer or Site Reviewer
A	Master Trainer or Other Trainer
B	Site Reviewer

11. CalOptima shall maintain certification records including, but not limited to, site review training activities and documentation to support the issuance of certificates.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health Network Service Agreement
D. CalOptima Policy HH.1101: CalOptima Provider Complaint
E. Department of Health Care Services (DHCS) Policy Letter (PL) 12-006: Revised Facility Site Review Tool
F. Department of Health Care Services (DHCS) Policy Letter (PL) 03-002: Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews
G. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004: Site Reviews: Facility Site Review and Medical Record Review
H. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 14-005: Facility Site Review / Physical-Accessibility Reviews
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-023: Facility Site Review Tools for Ancillary Service and Community-Based Adult Services Providers
J. National Committee for Quality Assurance (NCQA) 2019 Standards: MED 3-Practitioner Office Site Quality

VI. REGULATORY AGENCY APPROVALS

A. 04/30/15: Department of Health Care Services

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1608	PCP Site Reviews	Medi-Cal
Revised	01/01/1998	GG.1608	PCP Site Reviews	Medi-Cal
Revised	04/01/1999	GG.1608	PCP Site Reviews	Medi-Cal
Revised	08/01/2000	GG.1608	PCP Site Reviews	Medi-Cal
Revised	10/01/2002	GG.1608	Facility Site Reviews	Medi-Cal
Revised	10/01/2003	GG.1608	Facility Site Reviews	Medi-Cal
Effective	10/01/2005	MA.7011	Practitioner Office Site Reviews	OneCare
Revised	03/01/2007	MA.7011	Full Scope Practitioner Office Site Reviews	OneCare
Revised	04/01/2007	GG.1608	Facility Site Review	Medi-Cal
Revised	09/01/2011	MA.7011	Full Scope Site Reviews	OneCare
Revised	09/01/2011	GG.1608	Full Scope Site Reviews	Medi-Cal
Revised	02/01/2013	GG.1608	Full Scope Site Reviews	Medi-Cal OneCare
Revised	12/01/2014	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE

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Revised	12/01/2015	GG.1608Δ	Full Scope Site Reviews	Medi-Cal 1 OneCare 2 OneCare Connect PACE
Revised	05/01/2016	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	10/10/2017	GG.1608a	Facility Site Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608b	Medical Record Review Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608c	Facility Site Review and Medical Record Review Collaboration Process	Medi-Cal OneCare
Retired	10/10/2017	GG.1608d	Scoring Process for Facility Site Review and Medical Record Review	Medi-Cal OneCare
Retired	10/10/2017	GG.1608e	Facility Site Review and Medical Record Review Corrective Action Plan	Medi-Cal OneCare
Retired	10/10/2017	GG.1608f	Review Personnel, Training and Certification	Medi-Cal OneCare
Revised	10/01/2017	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2018	GG.1608Δ	Full Scope Site Reviews	Medi-Cal OneCare OneCare Connect PACE
Retired	02/13/2018	MA.7011	Full Scope Site Reviews	OneCare
Revised		GG.1608Δ	Full Scope Site Reviews	OneCare

IX. GLOSSARY

Term	Definition
Ancillary Service Provider Sites	Ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services such as radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations
Ancillary Services	For the purposes of this policy, ancillary services refers to diagnostic and therapeutic services such as, but not limited to: radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.
CBAS Providers Sites	CBAS provider sites include all facilities that provide bundled CBAS services, and do not include Licensed Only Adult Day Health Care centers and Programs of All-Inclusive Care for the Elderly (PACE). CBAS services (defined in W&I Code section 14550.5 and provided each day of attendance) include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on the participant's Individual Care Plan.
CBAS Services	For purposes of this policy, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.
Certified Site Reviewer (CSR)	An appropriately qualified and trained physician or registered nurse (RN) who is responsible for conducting provider site reviews, in accordance with DHCS Policy Letter 14-004 and subsequent updates.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as covered services under CalOptima's 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), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.

Term	Definition
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Critical Elements (CE)	Nine critical elements of the site review that defines the potential for adverse effects on patient health and safety, and has a scored weight of two points on the FSR tool.
Designee	For the purposes of this policy, a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role, as determined by CalOptima QI staff.
Facility Site Review (FSR) Survey	A DHCS tool utilized to assess the quality, safety, and accessibility of PCPs and high-volume specialists physician offices.
Full Scope Site Review	For the purposes of this policy, means a comprehensive site review as required by DHCS guidelines which encompass a Facility Site Review (FSR) and Medical Record Review (MRR) of a Primary Care Provider (PCP) site.
Health Network	A Physician Hospital Consortium (PHC), a 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 Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Medical Record	For the purposes of this policy, 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.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including high volume specialists, CBAS and ancillary service providers.
Potential Quality Issues (PQIs)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised.
Primary Care Provider (PCP)	For the purposes of this policy, a primary care provider may be a primary care practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

Term	Definition
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

1

Policy #:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/05
~~Last Review Date:~~	~~03/01/18~~
~~Last~~ Revised Date:	~~03/01/18~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes CalOptima's **Quality Improvement Committee (QIC)** and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for ~~Members~~**members** and ~~Providers~~**providers**; satisfaction for ~~Members~~**members** and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the **National Committee for Quality Assurance (NCQA)**.

II. POLICY

A. The **Quality Improvement Committee (QIC)** shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The **QIC** shall:

1. Ensure and improve the quality of ~~Member~~**member** care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to ~~Members~~**members**, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality ~~including, but not limited~~in order to:

   a. Improve quality of care received by ~~Members~~**members**;

   b. Increase ~~Member~~**member** satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of ~~Member~~**member** care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

   f. Collect clear, accurate, and appropriate date to analyze problems and measure improvement; and

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g. Coordinate and communicate department-specific and system-wide organizational information.

B. The ***QIC*** shall use a variety of ~~quality improvement~~Quality Improvement (QI) methodologies dependent on the type of opportunity for improvement identified (i.e., Plan/Do/Study/Act model).

III. PROCEDURE

A. Membership

1. The ***QIC*** Chairperson shall be the CalOptima Chief Medical Officer, ~~Deputy Chief Medical Officer~~ or ~~Designee~~**designee**, CalOptima.

2. The ~~Voting Members~~voting **members** shall consist of:

a. Four (4) ~~participating~~ physicians or practitioners, with at least two (2) practicing physicians or practitioners;

b. CalOptima Chief Medical Officer (CMO~~)/Deputy Chief Medical Officer (DCMO~~);

~~a.~~ CalOptima Medical ~~Director, Utilization Management (UM), also representing the UM Committee;~~

c. ~~CalOptima Medical Director, Behavioral Health (BH), also representing the BH QI Committee~~Directors;

d. Executive Director of Clinical Operations;

e. Executive Director of Network Management; and

f. Executive Director of Operations.

3. The ***QIC*** shall be supported by:

a. Executive Director of Quality and ~~Analytics~~Population Health Management;

b. Director of Quality Improvement;

c. Director of Quality Analytics;

d. Director, Population Health ~~Education & Disease~~ Management~~; and~~

e. Committee recorder as assigned.

B. Quorum

1. A quorum consists of a ~~majority~~minimum of ~~the~~six (6) voting ***members*** ~~at least six (6)~~ of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may

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proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as the attendance in person or participation by telephone.

C. The ***QIC*** shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating ***members*** of the ***QIC*** shall complete the confidentiality statement in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating ***members*** shall sign a Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her ~~Designee~~***designee*** shall report ***QIC*** activities to the ~~Quality Assurance Committee~~QAC and Board of Directors.

~~IV. ATTACHMENTS~~
IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee Flow Chart
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

A. 11/23/15: Department of Health Care Services

VII. BOARD ~~ACTIONS~~ACTION(S)

~~Not Applicable~~

~~REVIEW/~~None to Date

VIII. REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	10/01/2005	MA.7002	Quality Improvement Committee	Medi-Cal
Revised	04/01/2013	GG.1620	Quality Improvement Committee	Medi-Cal OneCare

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~~Version~~Action	Date	Policy ~~Number~~#	Policy Title	~~Line~~Program(s) ~~of Business~~
Revised	08/01/2015	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Member	An enrollee-beneficiary of a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

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Policy #:	GG.1620
Title:	**Quality Improvement Committee**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/05
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy describes CalOptima's **Quality Improvement Committee (QIC)** and the process by which CalOptima assures all quality improvement activities are performed, integrated, and communicated internally and externally and achieves the end results of optimal clinical outcomes for **members** and **providers**; satisfaction for **members** and other customers; maintenance of quality standards, licensing, and contract and regulatory compliance; and continued accreditation by the **National Committee for Quality Assurance (NCQA)**.

II. POLICY

A. The **Quality Improvement Committee (QIC)** shall provide overall direction for the quality management and improvement process and ensure that activities are consistent with CalOptima's strategic goals and priorities. The **QIC** shall:

1. Ensure and improve the quality of **member** care by objectively and systematically monitoring and evaluating the quality, timeliness, and appropriateness of clinical care and services provided to **members**, and pursue opportunities for improvement;

2. Design, manage, and improve all work processes that are related to clinical care, service, access, and quality in order to:

   a. Improve quality of care received by **members**;

   b. Increase **member** satisfaction;

   c. Minimize rework and costs;

   d. Minimize the time involved in delivery of **member** care and service;

   e. Improve organizational quality improvement functions and processes to both internal and external customers;

   f. Collect clear, accurate, and appropriate date to analyze problems and measure improvement; and

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g. Coordinate and communicate department-specific and system-wide organizational information.

B. The ***QIC*** shall use a variety of Quality Improvement (QI) methodologies dependent on the type of opportunity for improvement identified (i.e., Plan/Do/Study/Act model).

III. PROCEDURE

A. Membership

1. The ***QIC*** Chairperson shall be the CalOptima Chief Medical Officer, or **designee**, CalOptima.

2. The voting **members** shall consist of:

   a. Four (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners;

   b. CalOptima Chief Medical Officer (CMO);

   c. CalOptima Medical Directors;

   d. Executive Director of Clinical Operations;

   e. Executive Director of Network Management; and

   f. Executive Director of Operations.

3. The ***QIC*** shall be supported by:

   a. Executive Director of Quality and Population Health Management;

   b. Director of Quality Improvement;

   c. Director of Quality Analytics;

   d. Director, Population Health Management

   e. Committee recorder as assigned.

B. Quorum

1. A quorum consists of a minimum of six (6) voting ***members*** of which at least four (4) 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 the attendance in person or participation by telephone.

C. The ***QIC*** shall meet at least eight (8) times per calendar year, and report to the Board Quality Assurance Committee (QAC) quarterly.

D. Participating ***members*** of the ***QIC*** shall complete the confidentiality statement in accordance with GG.1628: Confidentiality of Quality Improvement Activities. Participating ***members*** shall sign a

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Conflict of Interest Attestation and Conflict of Interest Disclosure form in accordance with CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest.

E. The Chief Medical Officer and/or his or her ***designee*** shall report ***QIC*** activities to the QAC and Board of Directors.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Policy GG.1628: Confidentiality of Quality Improvement Activities
B. CalOptima Policy GG.1656Δ: Quality Improvement and Utilization Management Conflicts of Interest
C. Quality Improvement Program
D. Quality Improvement Committee Flow Chart
E. Quality Improvement Committee (QIC) Charter

VI. REGULATORY AGENCY APPROVAL(S)

A. 11/23/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	10/01/2005	MA.7002	Quality Improvement Committee	Medi-Cal
Revised	04/01/2013	GG.1620	Quality Improvement Committee	Medi-Cal OneCare
Revised	08/01/2015	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	04/01/2017	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	03/01/2018	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1620	Quality Improvement Committee	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Member	An enrollee-beneficiary of a CalOptima Program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Quality Improvement Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.

~~Policy #:~~	~~GG.1639A~~
~~Title:~~	~~**Post-Hospital Discharge Medication Supply**~~
~~Department:~~	~~Medical Affairs~~
~~Section:~~	~~Quality Improvement~~
~~CEO Approval:~~	~~Michael Schrader~~
Policy #:	GG.1639A
Title:	**Post-Hospital Discharge Medication Supply**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader
~~Effective Date:~~	~~11/1/14~~
~~Last Review Date:~~	~~11/1/15~~
~~Last Revision Date:~~	~~11/1/15~~
Effective Date:	11/01/2014
Revised Date:	TBD

~~This policy shall apply to the following CalOptima line of business (LOB):~~

Applicable to:

- ~~Medi-Cal~~
- ~~OneCare~~
- ~~OneCare Connect~~
- ~~PACE~~

- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

To describe the process by which CalOptima shall provide oversight of contracted hospitals to ensure that **Members** have access to seventy-two (72)-hour supply of covered outpatient drugs in an **emergency situation**.

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. Hospitals shall ensure that discharged **Members** have access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

~~A.~~ For ~~The CalOptima Director of Provider Network Management or designee shall manage the hospital contracting process.~~

~~B. CalOptima shall require credentialing of all contracted hospitals.~~

B. ~~CalOptima shall oversee only contracts with hospitals that are licensed for participation in the~~ the purpose of this policy, an emergency situation would include any covered outpatient drug needed for continuity of care that routinely require prior authorization, which would be delayed due to after-hours (nights, weekends and holidays), the 72-hour supply is an exception to the prior authorization processes.

~~C.~~ The Quality Improvement Department~~Medi-Cal program.~~

~~D.~~C. ~~CalOptima~~ shall monitor hospitals to ensure that a **Member** has access to at least a seventy-two (72-)-hour emergency supply of a covered outpatient or **Medically Necessary** medications when prior authorization is not available, and when the medication is needed without delay to prevent the **Member's** condition from worsening~~.~~.

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

~~E.~~D. Routine discharge prescriptions and prescriptions for an emergency supply of medication shall be filled at the **Member's** ~~Pharmacy~~pharmacy, in accordance with CalOptima ~~policy~~Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies.

~~CalOptima~~

E. CalOptima's Pharmacy Department shall monitor **Members** recently discharged from the hospital and assist the **Member** or the **Member's** pharmacy with access to at least a seventy-two (72-)-hour supply of **Medically Necessary** medications.

F. CalOptima's Customer Service Department shall inform **Members** of their right to receive the seventy-two (72)-hour covered outpatient drug supply through the ~~medication reconciliation program and Transition of Care program~~**Member** Handbook and at least annually through the **Member** newsletter.

~~G.~~ CalOptima's Provider Relations Department shall ~~ensure that the 72-hour emergency supply of the covered prescription drug is prepared and administered in accordance with the orders of a licensed independent practitioner responsible for the Member's care, and in accordance with all applicable laws and regulations.~~

~~4. CalOptima shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hour a day, 7 days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility~~, at ~~all times~~least annually, notify its providers, including~~:~~

~~H.~~G. ~~CalOptima shall ensure that appropriate~~ hospitals ~~are available and accessible to Members within~~, of this requirement through the provider ~~network to provide necessary high-risk pregnancy and delivery services.~~newsletter.

~~I.~~H. CalOptima's Quality Improvement Department shall document policies and procedures of CalOptima's network hospitals related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met~~,~~ ~~including, if applicable, specific language in network hospital subcontracts.~~ .

~~IV.~~III. PROCEDURE

~~A. CalOptima's Contracting department oversees and manages~~Hospitals shall ensure that the ~~Hospital contracting process in collaboration with CalOptima's Quality Improvement Department and Finance Departments~~discharged **Member** has ~~:~~

~~A. On an annual basis, CalOptima's Quality Improvement department shall monitor, via a signed attestation, and conduct an annual audit for validation of the attestation, of contracted hospitals' compliance with:~~

~~1. Applicable CalOptima policies and procedures;~~

~~B.~~A. ~~Emergency medication dispensing requirements of providing Members~~ access to at least a seventy-two (72-) hour supply of ~~covered outpatient or~~ any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

~~a. In order to receive reimbursement for emergency supply medications, the hospital pharmacy shall submit a prior approval request for the emergency supply. The request must clearly state the request is for the emergency 72 hour medications.~~

~~b. On a quarterly basis, the CalOptima Grievance Appeals Resolution Services (GARS) department shall ensure any grievances related to the dispensing of the 72 hour drug supply are isolated and reported to the the GARS committee, Quality Improvement Committee (QIC) and Delegation Oversight Committee (DOC).~~

~~c. On a quarterly basis, the Quality Improvement department shall monitor and report any Potential Quality Issues (PQI) in relation to the 72 hour drug supply to the QIC and DOC.~~

~~d. CalOptima shall inform Members of their right to receive the 72 hour drug supply through the Member Handbook and at least annually through the Member Newsletter.~~

~~e. CalOptima shall, at least annually, notify its providers, including hospitals, of this requirement through the Provider Newsletter.~~

CalOptima's Pharmacy Department

~~2. For designated emergency service facility, the facility has one or more Physicians and one (1) Nurse on duty in the facility at all times.~~

~~3. Appropriate hospitals are available and accessible to Members within the provider network to provide necessary high risk pregnancy and delivery services.~~

~~B. Oversight of Attestations~~

~~1. A random sample will be chosen, at a minimum, on an annual basis.~~

~~2. The Network Operations department shall validate compliance with the attested items.~~

~~3. On an annual basis, the results shall be reported to the Quality Improvement Committee (QIC) and Delegation Oversight Committee (DOC).~~

~~4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions~~

~~C. Contracted hospitals shall provide required policies and procedures to CalOptima upon request.~~

~~D. CalOptima shall, request a random sample of Medication Dispensing logs on at least a semi-annual basis.~~

~~E. CalOptima shall provide track and trend results via a semi-annual report to the QIC and DOC.~~

~~C.~~B. ~~On a quarterly basis, CalOptima~~ shall monitor and report pharmacy emergency overrides at the point of sale for hospital discharge ~~at the Pharmacy and Therapeutics Committee~~.

1. On a daily ~~basis~~ basis, a CalOptima Pharmacist shall conduct medication reconciliation for **Members** discharged from the hospital including emergency room admissions and assist **Members** in obtaining necessary discharge-related medications, provide telephonic medication counseling for high-risk medications started upon hospital discharge, and screen for duplication in therapy, drug-drug interactions, and potential dosing errors.

2. Upon a referral from a CalOptima **Transition of Care** Coach, a CalOptima Pharmacist shall review and address medication discrepancies and major medication-related problems for **Members** participating in the CalOptima **Transition of Care** Program. A CalOptima Pharmacist shall contact the **Member** to conduct discharge counseling, provide clinical recommendations to the ~~member~~**Member**, and notify the ~~member's~~**Member's** primary care provider of these recommendations. A CalOptima Pharmacist shall review the **Member's** discharge summary for the following:

   a. Discrepancies identified on the Medication Discrepancy Tool;

   b. Potential Drug-Drug interaction;

   c. Changes in medication regimen as a result of the hospitalization;

   d. New medication counseling;

   e. Medication access issues; and

   f. Medication adherence.

3. On a quarterly basis, findings will be reported to the Pharmacy and Therapeutics (P & T) Committee.

4. Quality of care issues identified by the CalOptima Pharmacy Department through the medication reconciliation and **Transition of Care** processes shall be reported to QI for investigation, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review.

C. CalOptima shall respond to **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply as described in CalOptima Policy HH.1102: CalOptima Member Complaint and shall conduct a review of the related grievance by a nurse pursuant to CalOptima Policy GG.1611: Potential Quality Issue Review.

D. On an annual basis, CalOptima's Quality Improvement Department shall monitor compliance through a random sample of CalOptima- and health network-contracted hospitals. The Quality Improvement Department shall request and review for compliance with this policy:

1. An attestation from the hospital attesting to adherence to this policy; and

2. Hospital policy demonstrating adherence to this policy.

E. Oversight Process

1. Semi-annually, **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply will be reviewed by the CalOptima Grievance Appeals Resolution Services (GARS) Department.

2. Semi-annually, the Quality Improvement Department shall monitor and report any **Potential Quality Issues (PQI)** in relation to the seventy-two (72)-hour covered outpatient drug supply to the **Quality Improvement (QI) Committee**.

3. Annually, the results of the monitoring from P & T and GARS Committees shall be reported to the **(QI) Committee**.

4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions for any hospital found to be out of compliance with this policy.

~~V.~~IV. ATTACHMENT(S)

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima ~~Pharmacy Management~~Contract with the Department of Health Care Services
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
~~A.~~D. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies~~.~~
~~B.~~E. CalOptima Policy ~~and Procedure HH.2002: Sanctions~~ GG.1600: Access and Availability Standards
F. CalOptima Policy ~~and Procedure~~GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
G. CalOptima Policy HH.2002Δ: Sanctions
~~C.~~H. CalOptima Policy HH.~~2005~~2005Δ: Corrective Action Plan
~~D. Department of Health Care Services Contract~~
I. CalOptima PolicyHH.1102, CalOptima Member Complaint
J. CalOptima Policy GG.1611: Potential Quality Issue Review
~~E.~~K. Section 1927(d)(5) of the Social Security Act
L. Welfare and Institutions Code §14185
M. Title 42 Code of Federal Regulations § 438.3(s)

~~VII.~~VI. REGULATORY AGENCY APPROVAL(S)

04/28/15:——— Department of Health Care Services

~~VIII.~~VII. BOARD ACTION(S)

~~Not Applicable~~

~~REVIEW/~~None to Date

~~IX.~~VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	11/01/2014	GG.1639Δ	Hospital Oversight	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2015	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare

				OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Medically Necessary	Reasonable and necessary services to protect life, to prevent illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
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.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Quality Improvement (QI) Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Policy #:	GG.1639Δ
Title:	**Post-Hospital Discharge Medication Supply**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader
Effective Date:	11/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

To describe the process by which CalOptima shall provide oversight of contracted hospitals to ensure that **Members** have access to seventy-two (72)-hour supply of covered outpatient drugs in an **emergency situation**.

II. POLICY

A. Hospitals shall ensure that discharged **Members** have access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

B. For the purpose of this policy, an emergency situation would include any covered outpatient drug needed for continuity of care that routinely require prior authorization, which would be delayed due to after-hours (nights, weekends and holidays), the 72-hour supply is an exception to the prior authorization processes.

C. The Quality Improvement Department shall monitor hospitals to ensure that a **Member** has access to at least a seventy-two (72)-hour emergency supply of a covered outpatient or **Medically Necessary** medications when prior authorization is not available, and when the medication is needed without delay to prevent the **Member's** condition from worsening.

D. Routine discharge prescriptions and prescriptions for an emergency supply of medication shall be filled at the **Member's** pharmacy, in accordance with CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies.

E. CalOptima's Pharmacy Department shall monitor **Members** recently discharged from the hospital and assist the **Member** or the **Member's** pharmacy with access to at least a seventy-two (72)-hour supply of **Medically Necessary** medications.

F. CalOptima's Customer Service Department shall inform **Members** of their right to receive the seventy-two (72)-hour covered outpatient drug supply through the **Member** Handbook and at least annually through the **Member** newsletter.

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

G. CalOptima's Provider Relations Department shall, at least annually, notify its providers, including hospitals, of this requirement through the provider newsletter.

H. CalOptima's Quality Improvement Department shall document policies and procedures of CalOptima's network hospitals related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met.

III. PROCEDURE

A. Hospitals shall ensure that the discharged **Member** has access to at least a seventy-two (72) hour supply of any **Medically Necessary** medications. The requirement can be met either by providing the seventy-two (72)-hour supply, or by providing an initial dose and a prescription for the remaining seventy-two (72)-hour supply.

B. CalOptima's Pharmacy Department shall monitor and report pharmacy emergency overrides at the point of sale for hospital discharge.

1. On a daily basis, a CalOptima Pharmacist shall conduct medication reconciliation for **Members** discharged from the hospital including emergency room admissions and assist **Members** in obtaining necessary discharge-related medications, provide telephonic medication counseling for high-risk medications started upon hospital discharge, and screen for duplication in therapy, drug-drug interactions, and potential dosing errors.

2. Upon a referral from a CalOptima **Transition of Care** Coach, a CalOptima Pharmacist shall review and address medication discrepancies and major medication-related problems for **Members** participating in the CalOptima **Transition of Care** Program. A CalOptima Pharmacist shall contact the **Member** to conduct discharge counseling, provide clinical recommendations to the **Member**, and notify the **Member's** primary care provider of these recommendations. A CalOptima Pharmacist shall review the **Member's** discharge summary for the following:

   a. Discrepancies identified on the Medication Discrepancy Tool;

   b. Potential Drug-Drug interaction;

   c. Changes in medication regimen as a result of the hospitalization;

   d. New medication counseling;

   e. Medication access issues; and

   f. Medication adherence.

3. On a quarterly basis, findings will be reported to the Pharmacy and Therapeutics (P & T) Committee.

4. Quality of care issues identified by the CalOptima Pharmacy Department through the medication reconciliation and **Transition of Care** processes shall be reported to QI for investigation, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review.

C. CalOptima shall respond to **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply as described in CalOptima Policy HH.1102: CalOptima Member Complaint

and shall conduct a review of the related grievance by a nurse pursuant to CalOptima Policy GG.1611: Potential Quality Issue Review.

D. On an annual basis, CalOptima's Quality Improvement Department shall monitor compliance through a random sample of CalOptima- and health network-contracted hospitals. The Quality Improvement Department shall request and review for compliance with this policy:

1. An attestation from the hospital attesting to adherence to this policy; and

2. Hospital policy demonstrating adherence to this policy.

E. Oversight Process

1. Semi-annually, **Member** grievances related to the seventy-two (72) hour covered outpatient drug supply will be reviewed by the CalOptima Grievance Appeals Resolution Services (GARS) Department.

2. Semi-annually, the Quality Improvement Department shall monitor and report any **Potential Quality Issues (PQI)** in relation to the seventy-two (72)-hour covered outpatient drug supply to the **Quality Improvement (QI) Committee**.

3. Annually, the results of the monitoring from P & T and GARS Committees shall be reported to the (**QI) Committee**.

4. A Corrective Action Plan shall be issued in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions for any hospital found to be out of compliance with this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services
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. CalOptima Policy GG.1403: Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies
E. CalOptima Policy GG.1600: Access and Availability Standards
F. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of Healthcare Delivery Organizations
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima PolicyHH.1102, CalOptima Member Complaint
J. CalOptima Policy GG.1611: Potential Quality Issue Review
K. Section 1927(d)(5) of the Social Security Act
L. Welfare and Institutions Code §14185
M. Title 42 Code of Federal Regulations § 438.3(s)

VI. REGULATORY AGENCY APPROVAL(S)

04/28/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	11/01/2014	GG.1639Δ	Hospital Oversight	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2015	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1639Δ	Post-Hospital Discharge Medication Supply	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Medically Necessary	Reasonable and necessary services to protect life, to prevent illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
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.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Quality Improvement (QI) Committee	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Service Area	The geographical area that DHCS authorizes CalOptima to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima is approved to operate in.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Policy:	GG.1660
Title:	**Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Financial Incentives and Pay for Performance Payments**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	
Effective Date:	
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy outlines the guidelines CalOptima must adhere to when structuring, implementing, and executing the financial incentives and Pay for Performance (P4P) payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) contracted with CalOptima.

II. POLICY

A. Unless otherwise stated, this Policy shall only be applicable to FQHCs and/or RHCs who enter a contract, or who have an existing contract, with CalOptima.

B. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed by the Department of Health Care Services (DHCS) for their reasonable costs in providing Covered Services to Members through the Prospective Payment System (PPS) Methodology.

C. CalOptima may contract with FQHCs or RHCs for financial incentive payments, such as risk pool payments, bonuses, or withholds; such financial incentive payments may also be referred to as Pay for Performance (P4P) payments.

1. All financial incentive payments, or P4P payments, provided to FQHCs or RHCs, as permitted under federal and state law, must be designed to ensure that they are not included in the calculations of wrap-around or supplemental payments made to the FQHC or RHC by the Department of Health Care Services (DHCS).

2. CalOptima shall not utilize financial incentives or P4P payments to pay an FQHC or RHC an additional rate per service or visit based exclusively on utilization.

D. In accordance with the DHCS guidance, CalOptima shall establish and maintain clear, objective criteria for the financial incentives and P4P payments disbursed to FQHCs and RHCs.

E. CalOptima may recognize outstanding performance and support ongoing improvement in the provision of quality health care to Members receiving services at FQHCs and RHCs. Specifically, the financial incentives and P4P payments may recognize and reward FQHCs and RHCs and their Providers for demonstrating quality performance.

Back to Agenda

F. CalOptima shall have written agreements in place with the FQHC or RHC prior to the start of the financial incentive or P4P payment period in which the financial incentive or P4P payment would apply.

1. The amount of the financial incentive or P4P payment may not be known in advance, as the amount may vary, based on the FQHCs or RHCs performance. However, the financial incentive or P4P payment agreement shall articulate the methodology that will be used to determine the financial incentive or P4P payment amount.

2. This requirement for written agreements shall be deemed to have been met if the CalOptima P4P payment guidelines published prior to the start of the program articulates the methodology and eligible providers for the financial incentive or P4P payments.

G. CalOptima shall evaluate the effectiveness of such financial incentive or P4P payments and adjust or discontinue them if they are determined ineffective upon evaluation.

H. CalOptima shall provide the DHCS, upon request, its written arrangement as well as policies and procedures for oversight and monitoring of financial incentives and P4P payments.

I. This Policy does not pertain to grant funding that CalOptima may provide to FQHCs or RHCs for the purposes of building suitable clinical infrastructure or adding clinical capacity to an FQHC or RHC, as such grants are not subject to reconciliation.

III. PROCEDURE

A. CalOptima shall provide FQHCs and RHCs the following:

1. Industry benchmarks and data-driven feedback on the quality improvement efforts.

2. Comparative information on CalOptima's performance.

B. CalOptima may structure financial incentives and P4P payments as, but need not be limited to, risk pool payments, bonuses, or withholds, provided the arrangement meets all conditions applicable to the DHCS reconciliation audit process and the standard FQHC/RHC federal claims process.

1. CalOptima shall ensure all financial incentive and P4P payment arrangements meet the applicable conditions of federal and state laws to avoid duplicate payment to FQHCs/RHCs for services paid through federal claims.

C. CalOptima shall enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive or P4P payment.

1. The financial incentives for P4P payments shall be similar to, but not less than, the amount other financial incentives or P4P payments CalOptima makes to non-FQHC or non-RHC contracted Providers who provide similar services.

D. CalOptima's P4P financial incentives and P4P payments requirements shall include:

1. CalOptima shall distribute performance and improvement allocations upon final calculation and validation of each measurement rate.

2. To qualify for payment, the FQHC or RHC must have a minimum denominator in accordance with program definitions.

3. To qualify for payments, an FQHC or RHC must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

4. Any separate OneCare Connect (OCC) Quality Withhold incentive dollars earned will be distributed based upon the methodology previously approved by the CalOptima Board of Directors.

5. Payments can be made annually or more frequently, at CalOptima's discretion, as defined in the P4P agreement.

E. On an annual basis, the CalOptima shall:

1. Evaluate the metrics in the P4P program and make recommendations for any program changes needed; recommended changes may be based upon the overall performance of the measure and the level of improvement left to achieve; and

2. Evaluate any changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) accreditation status, Centers for Medicare & Medicaid Services (CMS) Star Rating Status, and/or overall NCQA health plan rating.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Welfare and Institutions Code, Section 14132.100(h)
B. Centers for Medicare and Medicaid Services (CMS), State Medicaid Directors Letter, Policy Regarding FQHCs/RHCs, Dated 09/27/2000
C. Department of Health Care Services (DHCS) All Plan Letter 19-005: Federally Qualified Health Centers and Rural Health Clinics Financial Incentive and Pay for Performance Payment Policy
D. Title 42, Code of Federal Regulations (C.F.R.), Section 405.2469(c)
E. Title 42, United States Code (U.S.C.), Sections 1396a(bb), 1396b(m)(2)(A)(ix)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
02/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		GG.1660	Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Financial Incentives and Pay for Performance Payments	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
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.
Covered Services	Medi-Cal: 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. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Federally Qualified Health Center (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.
Member	An enrollee-beneficiary of a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Pay for Performance (P4P)	Pay-for-performance is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements may provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients.

Term	Definition
Prospective Payment System (PPS)	A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment from CMS is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, FQHCs, RHCs, and skilled nursing facilities.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Rural Health Clinic (RHC)	An RHC is a clinic located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases and meets all other requirements of 42 CFR 405 and 491. The RHC is intended to increase access to primary care services for patients in rural communities. RHCs may be public, nonprofit, or for-profit healthcare facilities.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 12, 2019

ALL PLAN LETTER 19-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS FINANCIAL INCENTIVE AND PAY FOR PERFORMANCE PAYMENT POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification and guidance to Medi-Cal managed care health plans (MCPs) on the policy requirements for financial incentive payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

BACKGROUND:
FQHCs and RHCs provide covered health care services to Medi-Cal beneficiaries in federally designated medically underserved rural or urban areas and are a critical part of the health care delivery system's safety net. Per federal law, FQHCs and RHCs are to be reimbursed for their reasonable costs in providing covered health care services to Medi-Cal beneficiaries through the Prospective Payment System (PPS) methodology.[1] Depending on the delivery system, FQHCs and RHCs are reimbursed for covered services either by a MCP or their delegated entity or subcontractor, with an accompanying wrap-around payment from the Department of Health Care Services (DHCS) when applicable, or by DHCS directly through a fee-for-service (FFS) payment.[2] The Medi-Cal managed care payment with an accompanying wrap-around payment, or the FFS payment, must constitute the full PPS payment that the FQHC or RHC is entitled to receive, subject to required reconciliation audit processes.

Additionally, MCPs may contract with FQHCs or RHCs for financial incentive payments, such as risk pool payments, bonuses, or withholds. Such financial incentive payments can also be referred to as Pay-For-Performance (P4P) payments. All financial incentive or P4P payments provided to FQHCs or RHCs, as allowable under federal and state

[1] Title 42, United States Code, Section 1396a(bb).
[2] As of March 2018, 82% of Medi-Cal beneficiaries were covered by MCPs, and 18% by FFS according to the March 2018 Medi-Cal Monthly Enrollment Fast Facts report, is available at the following link: https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_March2018_ADA.pdf.

law,[3] are prohibited from being included in the calculation of wrap-around or supplemental payments made to the FQHC or RHC by DHCS. This policy is further clarified in the Centers for Medicare and Medicaid Services' State Medicaid Directors (SMD) Letter (dated September 27, 2000) titled, Policy Regarding FQHCs/RHCs.[4]

POLICY:
DHCS requires MCPs to act in accordance with DHCS' Policy Regarding Financial Incentive or P4P Payments for FQHCs and RHCs in Medi-Cal Managed Care.[5]

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

[3] Title 42, Code of Federal Regulations, Section 405.2469(c) and California Welfare and Institutions Code, Section 14132.100(h).
[4] This SMD is available at the following link: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf.
[5] DHCS' Policy Regarding Financial Incentive or P4P Payments for FQHCs and RHCs in Medi-Cal Managed Care is located at the following link: https://www.dhcs.ca.gov/dataandstats/reports/Documents/FQHCRHCFinancialIncentiveP4PPaymentPolicy.pdf.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

5. Consider Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve Fiscal Year 2020 (Measurement Year 2019) "Pay for Value (P4V) Program" for Medi-Cal and OneCare Connect (OCC)," which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis included evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, the staff analyzed the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, the staff evaluated any changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status and/or overall NCQA Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including CalOptima Community Network (CCN) is consistent with the P4V programs of the prior three years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Discussion

For the Measurement Year 2019 programs, staff recommends maintaining the tenets from the prior year, with some modifications.

For the Medi-Cal line of business, staff recommends no changes to the incentivized Adult and Child clinical and member experience performance measures. Both Adult and Child measures remain in the measurement set and weighting by acuity (SPD vs. non-SPD) will carry forward in the proposed MY

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2019 P4V program. Staff propose one additional measure to be added to the Medi-Cal measurement set.

Measurement Year 2019 Medi-Cal P4V Display Measure Changes:

Recommendation: Addition of one new Display measure:

- Persistence of Beta Blocker treatment after a Heart attack

Clinical guidelines recommend prescribing a beta-blocker after a heart attack to prevent another heart attack from occurring. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. Current CalOptima performance based on measurement year 2017 performance is at the National NCQA Medicaid 25th percentile which is well below the National Medicaid average at the 75th percentile.

Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY2020. For example, Colorectal Screening is now proposed to move from a Display measure to a Pay for Value clinical measure.

Measurement Year 2019 OneCare Connect P4V Measures Changes:
For the OneCare Connect line of business, staff recommends one change to the clinical performance measures and one addition to the clinical display measures.

Recommendation: Addition of one new Clinical measure:

- Colorectal Cancer Screening

Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends that adults age 50 to 75 be screened for colorectal cancer. Current CalOptima performance based on measurement year 2017 performance is at the two-star CMS Rating. Our goal is to achieve three star or higher rating from CMS on all quality metrics in the Star Rating set.

Recommendation: Addition of one new Clinical Display measure:

- Comprehensive Diabetes Care Nephropathy Monitoring

Clinical guidelines recommend annual screening or monitoring test for diabetics for evidence of nephropathy. This includes urine protein tests, evidence of treatment for nephropathy, stage 4 chronic kidney disease, end stage renal disease, kidney transplant, or visit to a nephrologist or prescription for one ACE/ARB medication.

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Distribution of Incentive Dollars

There are no proposed changes to the previously-Board-approved distribution strategy for earned pay for value dollars. The following P4V program requirements will remain:

- All health networks will continue to have performance measures for both adult and child care.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.
- To qualify for payments, a health network or physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon the methodology previously approved by the Board of Directors.
- Payments can be made annually or more frequently, at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement year 2019 payout will remain the same as previously approved by the Board of Directors.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V program will not exceed $2.00 per member per month (PMPM) and the OCC P4V program will not exceed $20.00 PMPM for the MY of January 1, 2019, through December 31, 2019. Since the distribution of incentive dollars for the MY 2019 P4V programs for Medi-Cal and OneCare Connect will be made in Fiscal Year 2020-21, Management will include expenses related to the MY 2019 P4V program in a future operating budget.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachments

1. FY 2020 (MY 2019) Medi-Cal and OneCare Connect Pay for Value Program Measurement Set
2. PowerPoint Presentation to Board of Directors' Quality Assurance Committee: Measurement Year 2019 Pay for Value Program Proposed Changes

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

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Attachment 1: FY 2020 (MY 2019) Medi-Cal and OCC
Pay for Value Program Measurement Set

Adult Measures	**2019 Measurement Year / HEDIS 2020 Specifications** **Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Prevention:</u> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <u>Diabetes (CDC):</u> • HbA1c < 8.0 (adequate control) • Retinal Eye Exams <u>Access to Care</u>: • Adults Access to Preventive/Ambulatory Care (AAP) <u>Respiratory</u>: • Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance • Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Adult Measures	**2019 Measurement Year / HEDIS 2020 Specifications** **Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate	A relative point system by measure based on: • NCQA CA CAHPS percentiles • Percentile Improvement
Display Measure	• Initial Health Assessment • Persistence of Beta Blocker treatment after a Heart Attack	• DHCS percentiles • NCQA National HEDIS percentiles

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Pediatric Measures	2019 Measurement Year / HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory: • Medication Management for People with Asthma (MMA) - 5-11 years 75% Compliance • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention: • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Well Child Visits in the First 15 months of Life –six well child visits (W15) Access to Care: • Children's Access to Primary Care Physician (CAP)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Pediatric Measures	**2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate	A relative point system by measure based on: • NCQA CA CAHPS percentiles • Percentile Improvement

OneCare Connect Measures	**2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	Measures: • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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Measurement Year 2019 Pay for Value Program Proposed Changes

Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019

Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics

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Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
  - NCQA Accreditation
  - Pay4Value
  - Health Plan Ratings
  - Model of Care
  - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time, and the level of improvement left to achieve.

P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
  - Preventive screenings for children and adults
  - Chronic Care Measures
  - Outcomes based Measures
  - Member Experience
  - Utilization/Readmissions
- Measures must be actionable by PCP's:
  - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks on their performance on P4V measures.
- Reporting Administrative Data Only

Medi-Cal P4V Measures

P4V Recommendations:

- No changes to Medi-Cal Adult measures for MY 2019.
- No changes to Medi-Cal Child measures for MY 2019.
- No changes to CAHPS Survey measures but the CAHPS benchmarks were changed to California benchmarks from National benchmarks for MY 2018 and will remain in place for MY 2019.
- Prefer measures to remain in program for at least 2-3 years for health networks to adapt to changes.
- Based on recommendation from Chronic Care conditions team, adding “Persistence for Beta Blocker Treatment after a Heart Attack” as a Display Measure (< 25th percentile currently).

Medi-Cal P4V Clinical Measures - Adult

Measurement Year 2019 – NO CHANGES	
Adult	**Quality Strategy**
Adult Access to Preventive Care Services	Area of HEDIS auditor focus due to declining rates; at 10th percentile Nationally
Breast Cancer Screening	Accreditation and Health Plan Rating
Cervical Cancer Screening	Accreditation, DHCS, and Health Plan Rating
Diabetes Care: HbA1c <8.0% (adequate control)	Accreditation and Health Plan Rating
Diabetes Care: Retinal Eye Exams	Accreditation, DHCS, and Health Plan Rating
Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance	Accreditation, Health Plan Rating
Avoidance of Antibiotic Treatment in Adults with Bronchitis	Accreditation

Medi-Cal P4V Clinical Measures - Child

Measurement Year 2019 – NO CHANGES	
Child	**Quality Strategy**
Adolescent Well-Care Visits	Health Plan Rating
Appropriate Testing for Children with Pharyngitis	Accreditation and Health Plan Rating
Appropriate Treatment for Children with URI	Accreditation and Health Plan Rating
Childhood Immunizations: Combo 10	Accreditation and Health Plan Rating
Children's Access to Primary Care Providers	Area of HEDIS Auditor focus; below 50th percentile
Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant	Accreditation, DHCS, and Health Plan Rating
Well-Child Visits 3–6 Years	DHCS and Health Plan Rating
Well Child Visits in the first 15 Months of Life	Health Plan Rating

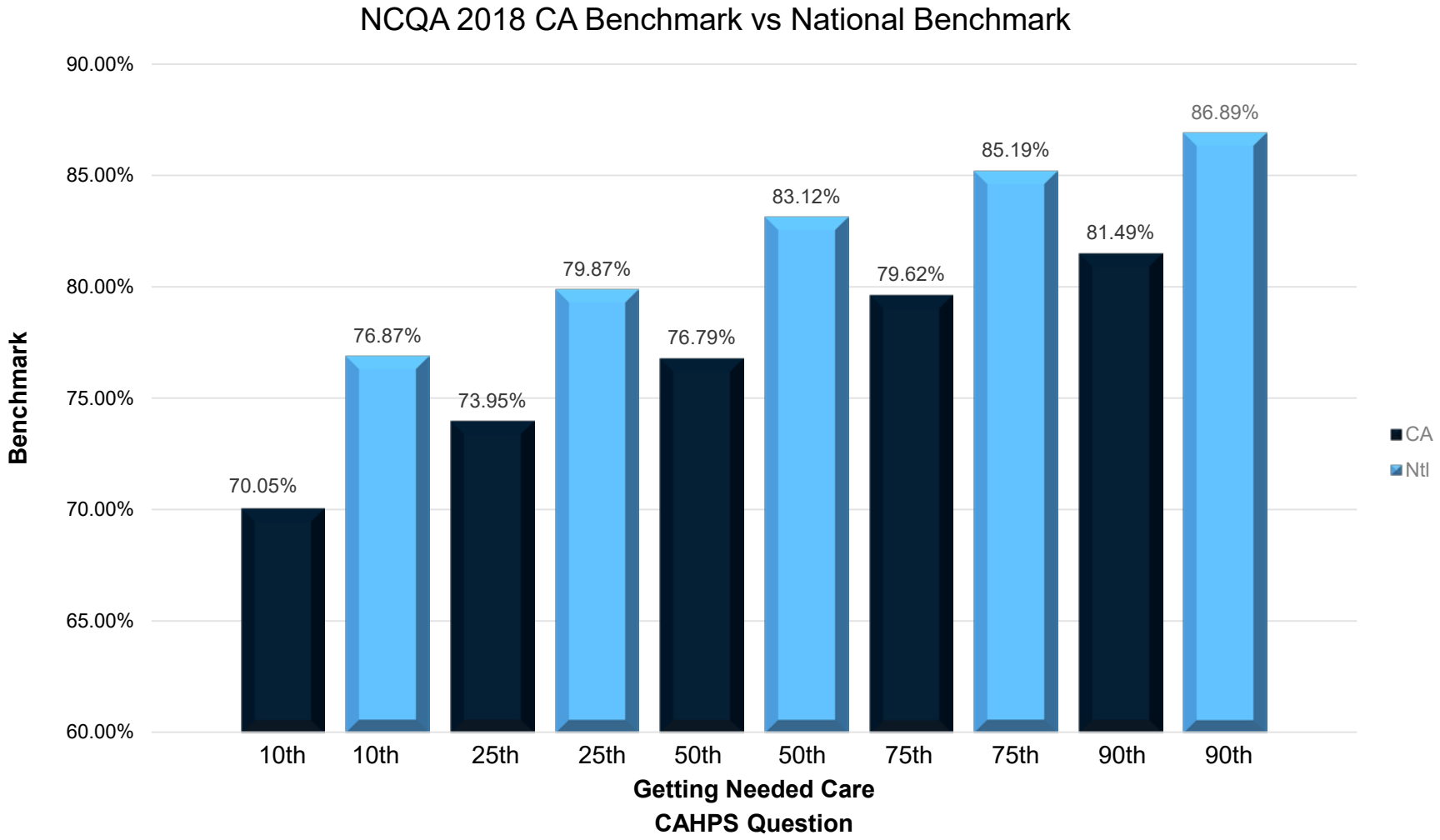
Medi-Cal P4V Display Measures

Measurement Year 2019	
Display	**Quality Strategy**
Initial Health Assessment	DHCS focus measure
NEW: Persistence for Beta Blocker Treatment after a Heart Attack	Health Plan Rating

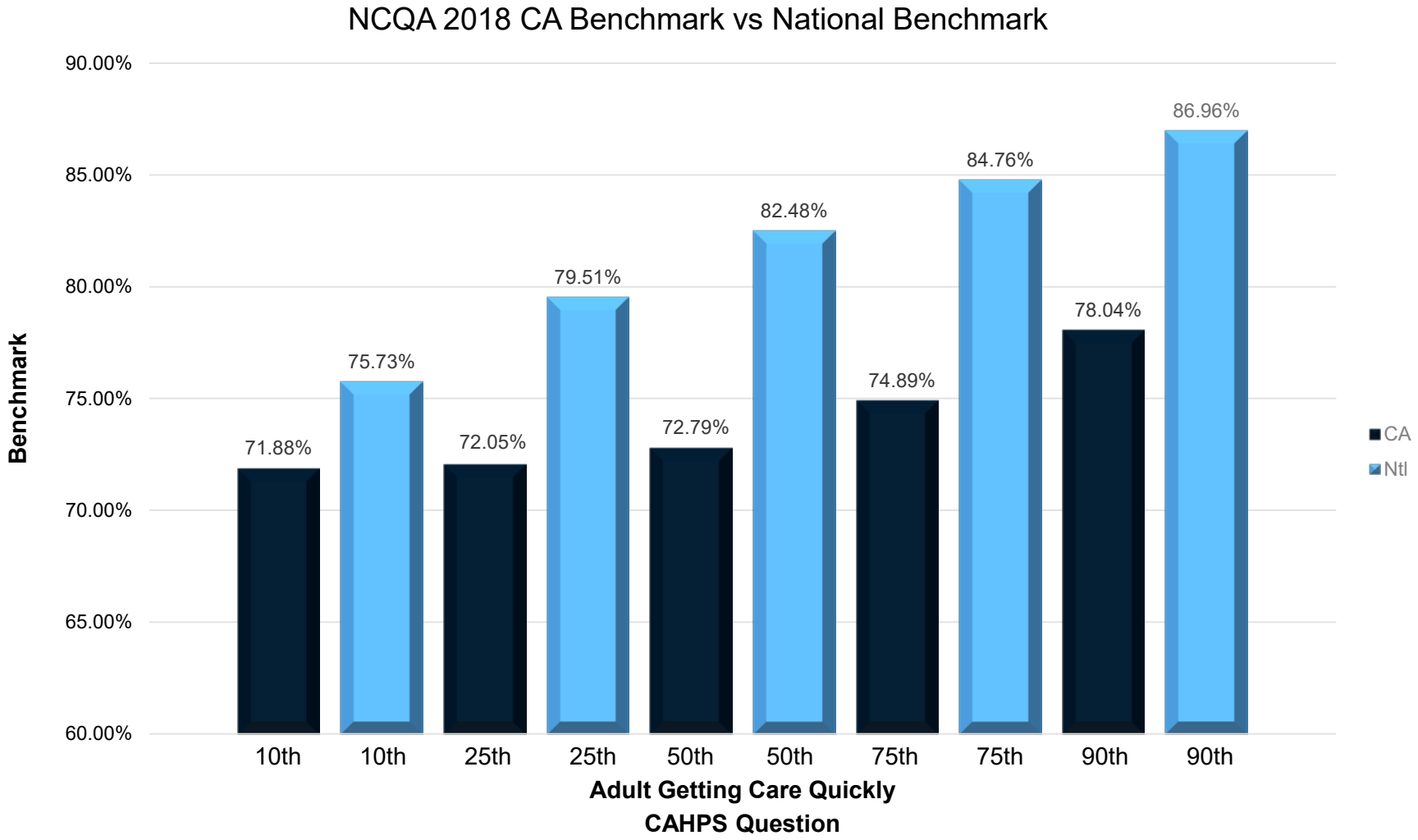
Medi-Cal P4V CAHPS Measures

Measurement Year 2019 – NO CHANGES	
Adult and Child Measures	
Getting Needed Care	Accreditation and Health Plan Rating
Getting Care Quickly	Accreditation and Health Plan Rating
Rating of PCP	Accreditation and Health Plan Rating
How well Doctors Communicate	Accreditation

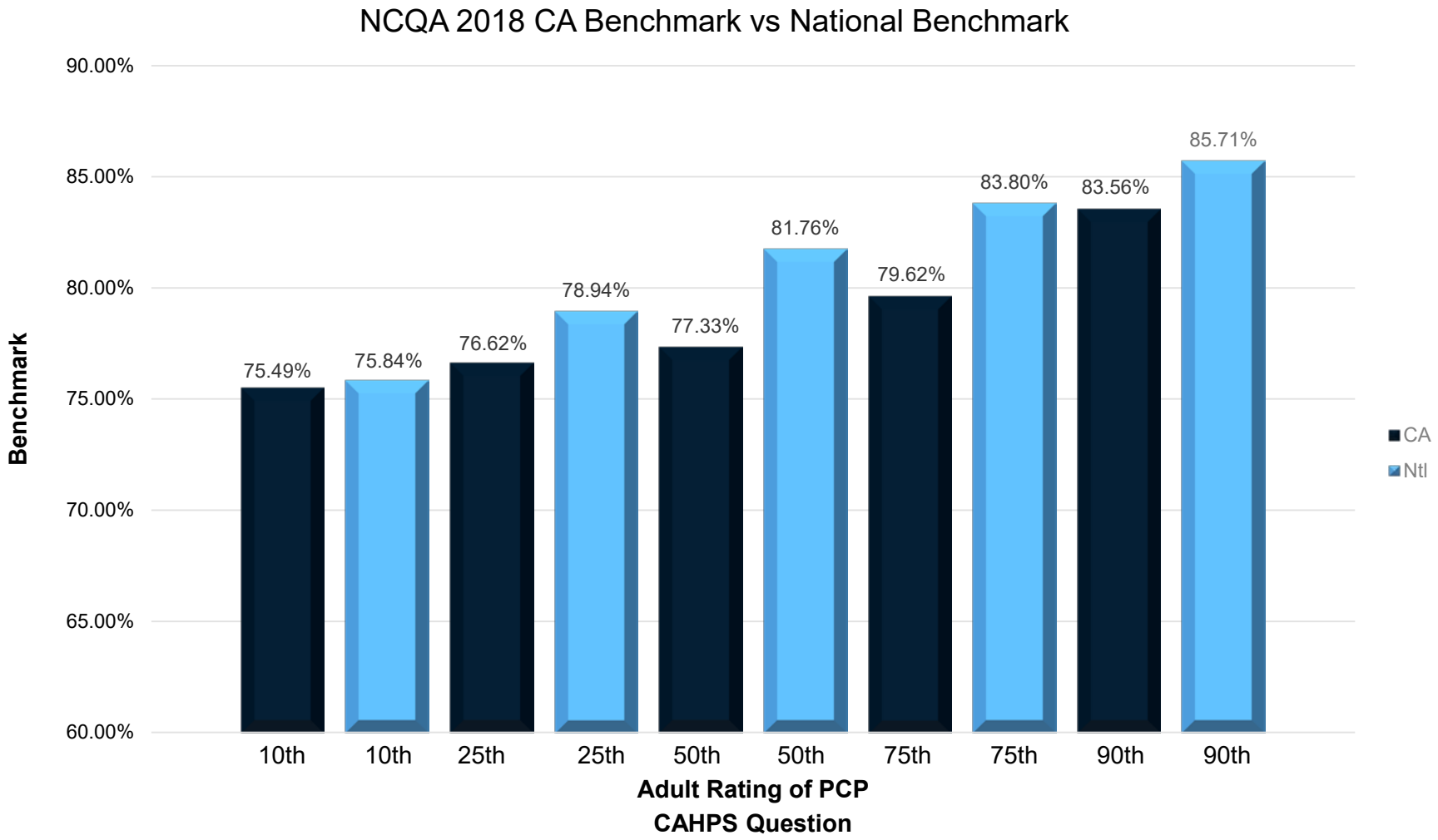
Adult CAHPS Benchmark Comparison



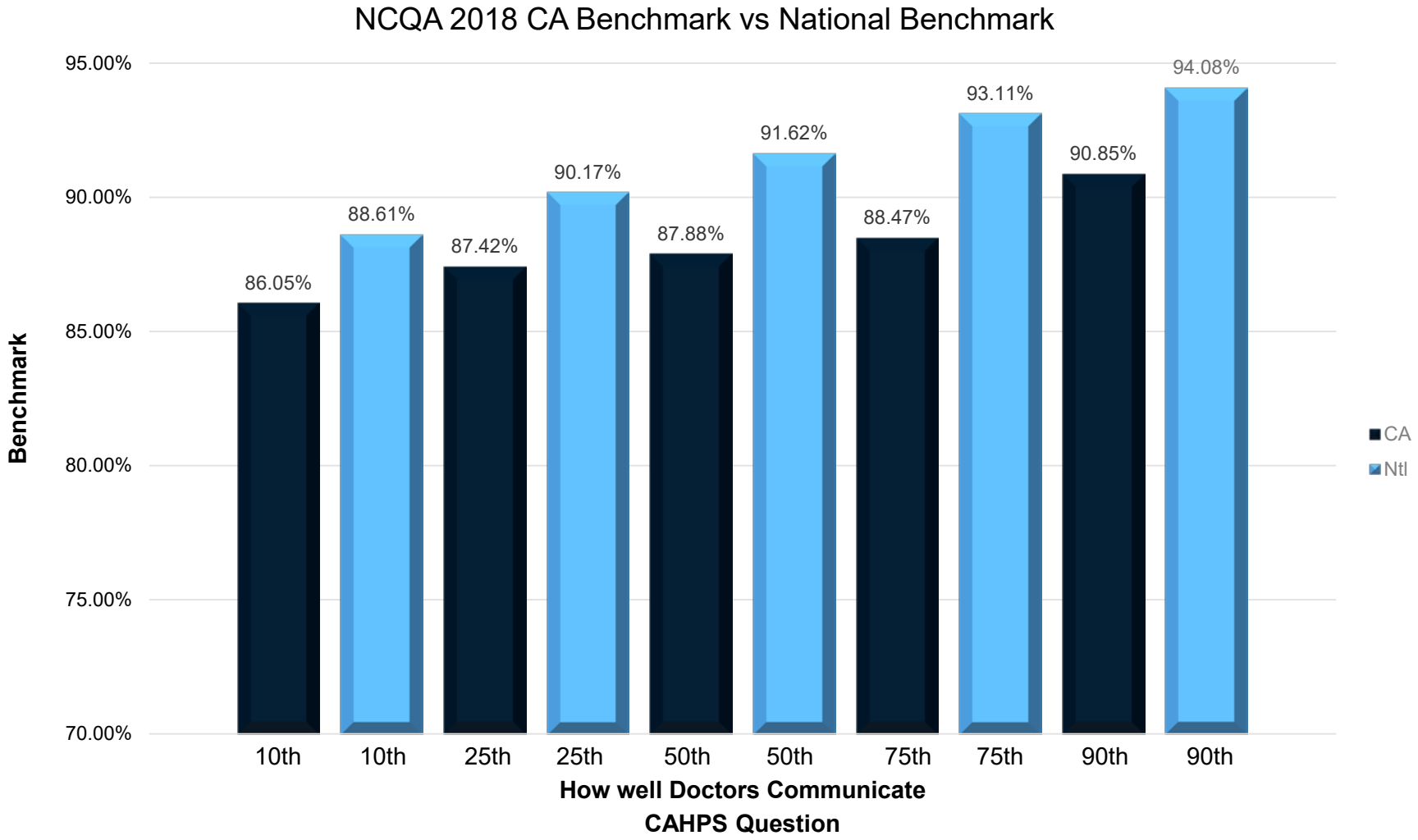
Adult CAHPS Benchmark Comparison



Adult CAHPS Benchmark Comparison



Adult CAHPS Benchmark Comparison



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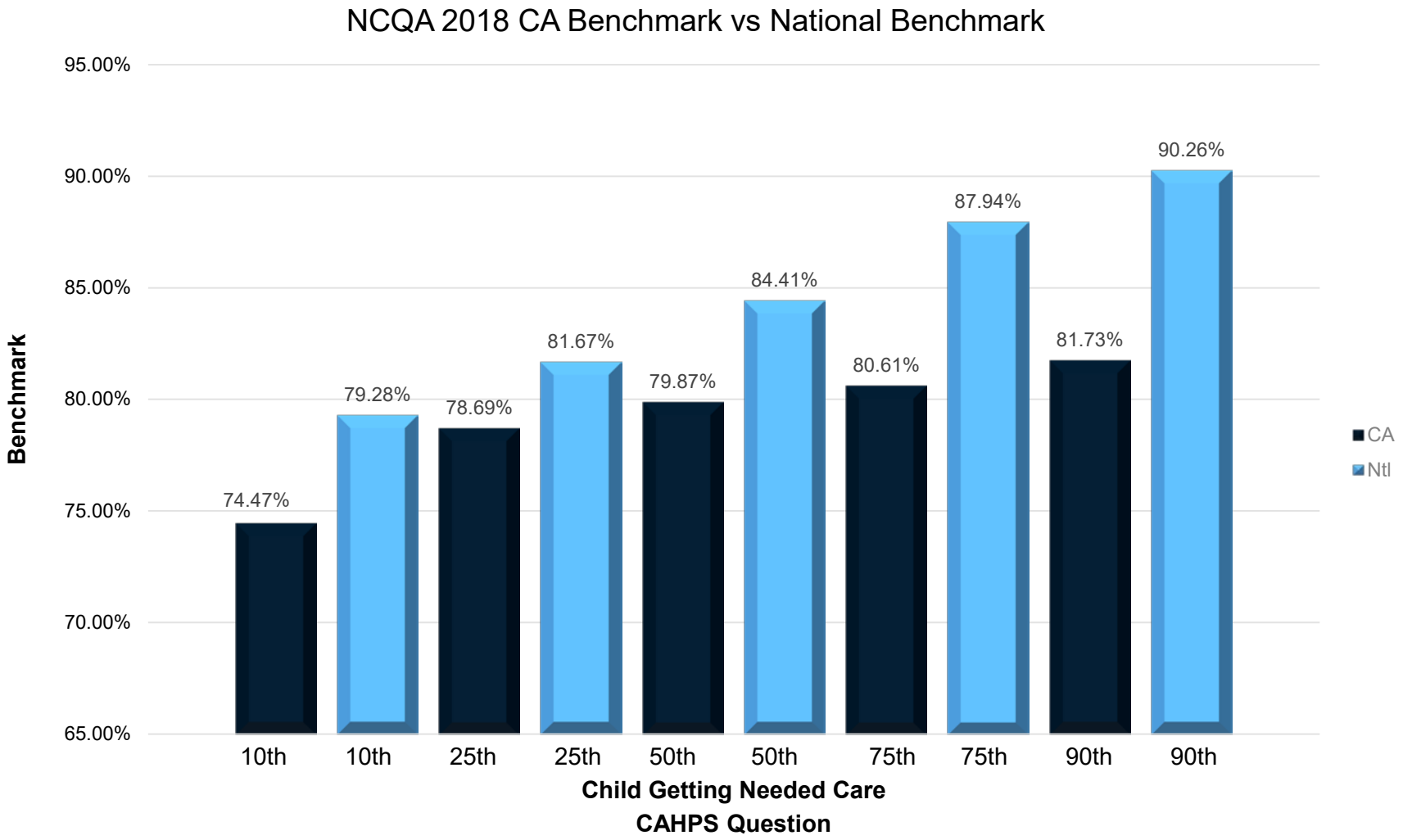
Child CAHPS Benchmark Comparison



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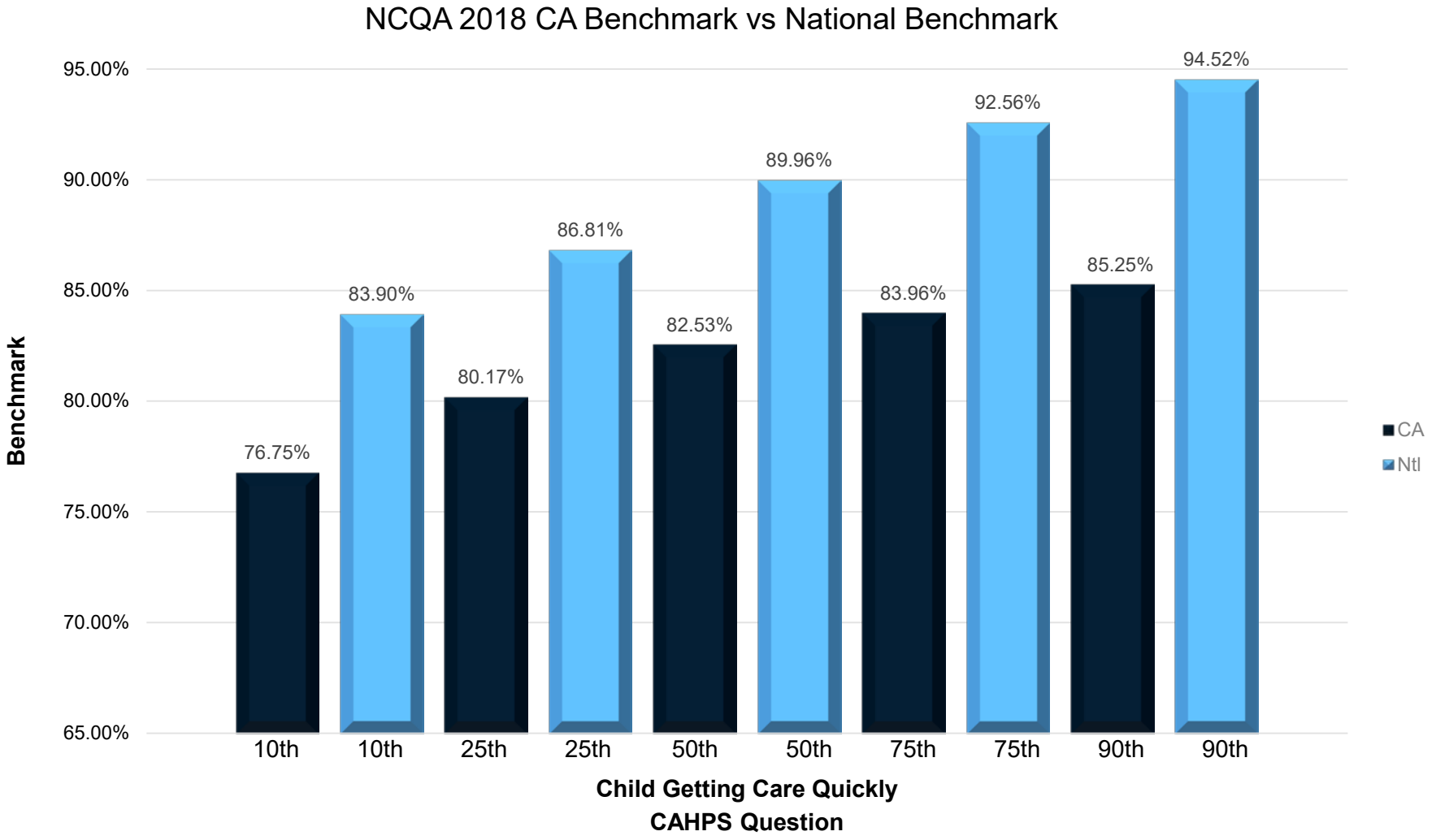
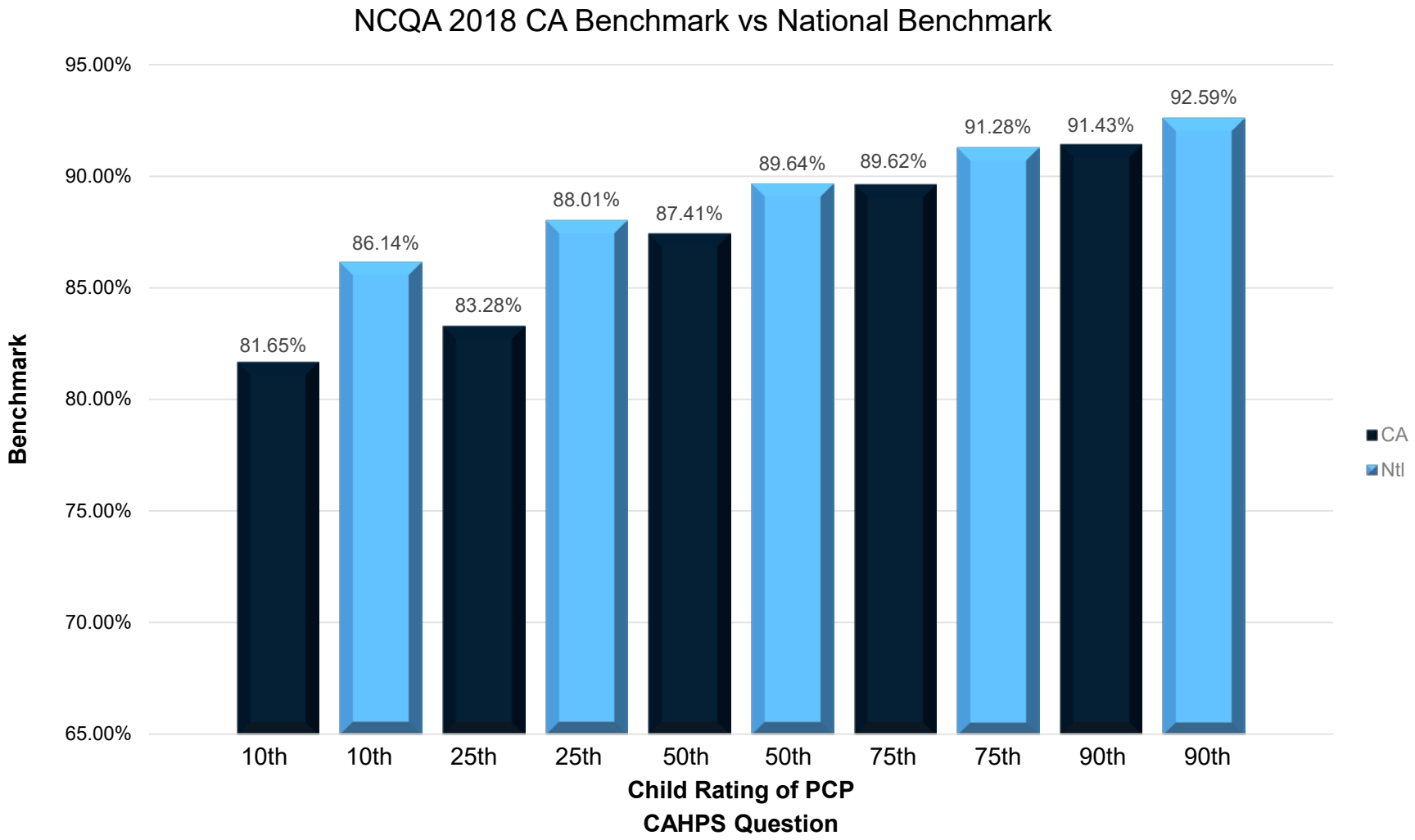
Child CAHPS Benchmark Comparison



Child CAHPS Benchmark Comparison



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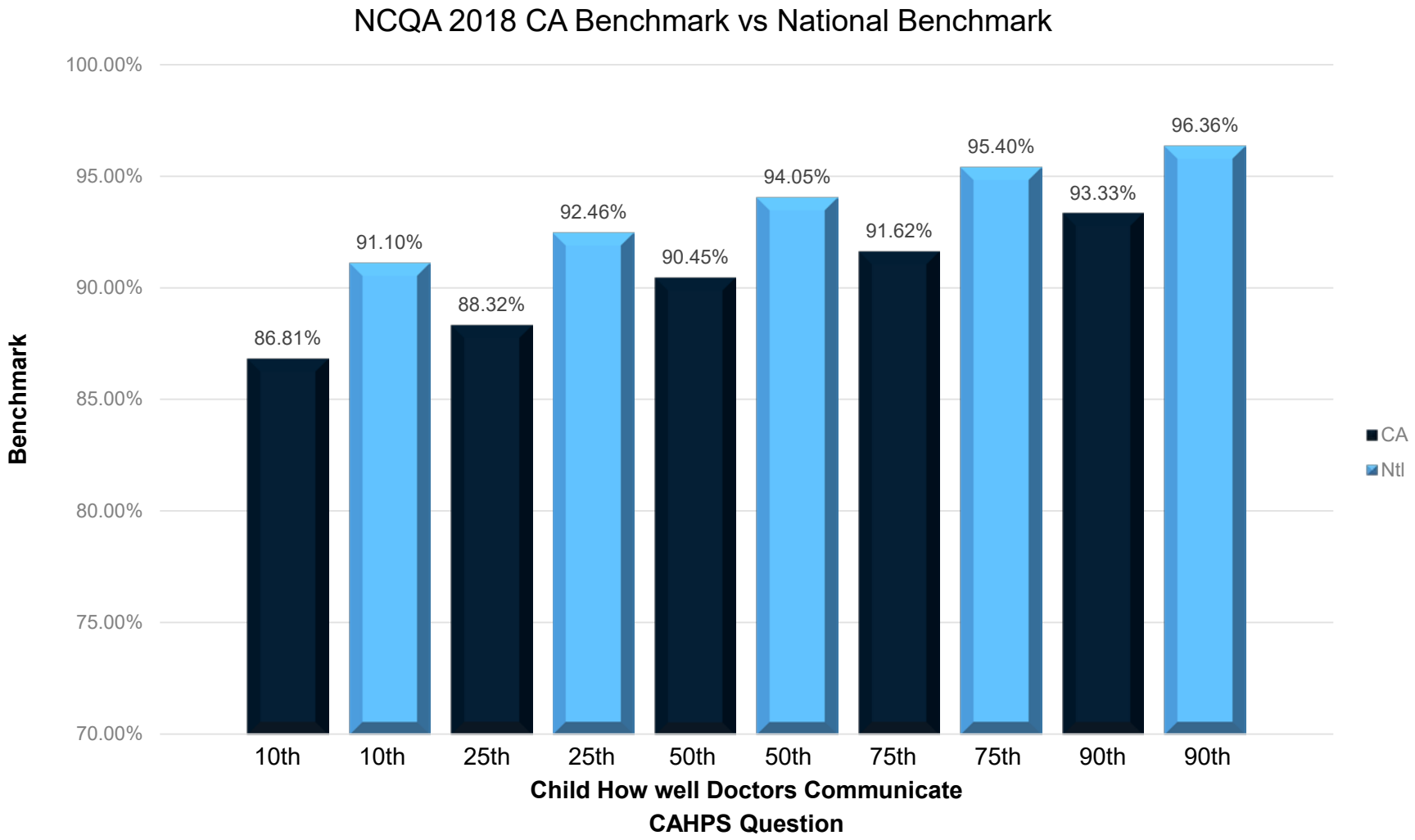
Child CAHPS Benchmark Comparison



OneCare Connect P4V Measures – MY 2019

P4V Recommendations:

- One change to OneCare Connect measures for MY 2019.
- Colorectal Screening to be moved from a Display measure to a P4V measure.
- CDC Nephropathy Monitoring to be included as a Display Measure for MY2019.
- No changes to OneCare Connect CAHPS Survey measures.

OneCare Connect P4V Measures

Measurement Year 2019	
Breast Cancer Screening	Model of Care and STAR measure
Diabetes Care – HbA1c poor control (>9.0%)	STAR measure
Medication Adherence for Diabetes Medications (Part D measure)	Model of Care, STAR, and Quality Withhold
Plan All-Cause Readmissions	STAR and Quality Withhold measure
NEW: Colorectal Cancer Screening	Model of Care and STAR

OneCare Connect P4V CAHPS Measures

Measurement Year 2019 – NO CHANGES	
Annual Flu Vaccine	STAR
Getting Appointments and Care Quickly	Model of Care and STAR
Getting Needed Care	Model of Care and STAR
Rating of Healthcare Quality	Model of Care and STAR

OneCare Connect P4V Display Measure

Measurement Year 2019	
NEW: Diabetes Care - Nephropathy Monitoring	STAR measure

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Actions Related to CalOptima's Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers Contracted with the CalOptima Community Network for the OneCare Connect Program

Contact

David Ramirez, M.D. Chief Medical Officer, 714-246-8400
Betsy Ha, R.N., M.S. Executive Director, Quality and Population Health Management 714-246-8400

Recommended Action

1. Approve CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers, authorize the Chief Executive Officer (CEO) to establish a OneCare Connect (OCC) CalOptima Community Network (CCN) Primary Care Engagement and Clinical Documentation Integrity Program, and approve disbursement methodology ~~and authorize the CEO, with the help of Legal Counsel, to execute agreements and/or contract amendments as necessary for implementation~~; and
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Rev. 5/7/20

Background

Cal MediConnect was launched in 2014 as a three-year demonstration program implemented across eight (8) counties. OCC was launched June 1, 2015, in Orange County. In support of this program, CalOptima contracted with the delegated health networks to manage services to the network's assigned membership. In total, OCC has approximately 14,200 members of which CCN makes up approximately 12%.

On June 6, 2019, the Board of Directors approved the CalOptima OCC Fiscal Year (FY) 2019–20 Operating Budget which included $3.4 million to cover Quality Incentive payments/initiatives.

In the most recent 12-month reporting period available, 87% of all CCN OCC members had at least one visit with their Qualified Provider. This result is below the 25th percentile compared to national Medicaid benchmarks.

Discussion

CalOptima routinely submits diagnosis data to the Centers for Medicare & Medicaid Services (CMS) for OCC members. In order to submit accurate and timely data, staff relies on CalOptima's contracted provider partners to deliver quality care to members and submit appropriate documentation on their medical conditions based on the annual visit. Staff recommends implementation of a new program to increase member access to annual primary care visits and accuracy and completeness of medical records. Timely access to annual PCP visits will ultimately improve member experience, quality of care and clinical documentation.

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Under the Primary Care Engagement and Clinical Documentation Integrity Program, CalOptima will give PCP's an attestation form listing quality measures and chronic condition diagnosis codes individualized for each of their assigned members for clinical validation during a face-to-face visit. The provider will be responsible for completing the attestation form and returning the form along with supporting clinical documentation to CalOptima. Once the submitted information has been reviewed and verified for completeness and accuracy, CalOptima will issue a payment to the provider of $150 per member per calendar year.

Proper coding will lead to improvements in quality measures for Healthcare Effectiveness Data and Information Set (HEDIS) reporting and ensures that CalOptima receives appropriate revenue through risk adjustment. The Primary Care Engagement and Clinical Documentation Integrity Program will also streamline chart retrieval for quality measurement. This will increase accessibility of charts during the annual HEDIS Chart Review and the CMS Risk Adjustment Data Validation (RADV) audit.

CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers was created to establish the reimbursement process to promote timely annual PCP visits while improving clinical documentation. Effective with dates of service on or after March 1, 2021, a qualified provider contracted with CCN for the OCC program may submit a completed attestation with supporting documentation of the member visit to receive a supplemental payment.

Staff projects the annual cost for the Primary Care Engagement and Clinical Documentation Integrity Program at $613,000. Specifically, the provider supplemental payments for the medical records are projected at an annual cost of $330,000, and the annual expense to add a Senior Program Manager and a Medical Record Review Specialist responsible for provider education and medical record review is estimated at $283,000. The anticipated start date of the program is January 2021.

As CalOptima's diagnosis data submission improves, staff anticipates that increased revenue will fully offset program expenses over time.

Fiscal Impact

The recommended action to authorize the Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers, based on the anticipated start date of January 2021, is estimated at $307,000 for the fiscal year. Upon approval, staff will include the estimate revenue and expense related to this program in the CalOptima FY 2020–21 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends authorizing the recommended actions to improve member access to annual visits, quality and funding available for OneCare Connect members.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers
2. Presentation HCC CCN Attestation Program

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

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Policy:	CMC.2001
Title:	**Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers contracted with the CalOptima Community Network (CCN) for the OneCare Connect (OCC) Program.

II. POLICY

A. The Primary Care Engagement and Clinical Documentation Integrity Program aims to improve Member engagement with their Qualified Provider and clinical documentation accuracy and completeness in Medical Records. CalOptima's contracted CCN OCC Qualified Providers will be incentivized for reporting confirmed condition diagnosis codes and reviewing preventive care needs for each CCN OCC Member based on a timely face-to-face encounter and properly documenting such information in Medical Records.

B. Qualified Providers may earn supplemental payment after completing a comprehensive annual visit with their assigned Member which shall be verified by CalOptima based on the Qualified Provider's attestation and supporting Medical Records to achieve the following quality goals:

1. Improve Member engagement with their Qualified Provider measured by the percentage of CCN OCC Members who have at least one (1) annual visit with their assigned Qualified Provider.

2. Improve the accuracy and completeness of clinical documentation and the submission of condition codes measured by successful completion of an attestation form by Qualified Providers.

C. For dates of service on and after March 1, 2021, a Qualified Provider is eligible if:

1. The Member is eligible with OCC and assigned to CCN as of the date of service (DOS);

2. The Qualified Provider addresses and documents medical conditions in at least one face-to-face visit with the Member within the Service Year;

3. The Qualified Provider conducts a comprehensive assessment and addresses all health conditions as noted on the attestation during the face-to-face visit and as provided in Section II.B.;

4. The Qualified Provider submits the completed attestation to CalOptima with supporting Medical Records by the required deadline; and

5. The CalOptima Quality Improvement Department verifies that the potential Healthcare Effectiveness Data and Information Set (HEDIS) preventive care measures and health condition codes suggested in the attestation form are documented in the supporting medical records. HEDIS specifications include both International Classification of Diseases, Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes, which are used for hierarchical condition category (HCC) coding. HEDIS measures are quality measures designed to indicate how well preventive care is being carried out by a plan and its providers and assists CalOptima in ensuring that Members' preventive care needs are being addressed, along with their acute and chronic care needs. Accurate clinical documentation benefits both HEDIS and HCC coding. These HEDIS and health condition codes vary by Member.

D. The CalOptima Quality Improvement Department conducts oversight of the attestation accuracy and completeness of Medical Record documentation through random sample reviews and identifies an opportunity to improve clinical documentation integrity. The attestation form serves as evidence of a Medicare Annual Wellness Visit (AWV). As demonstrated in journal articles, Members with access to AWV are likely to complete preventive services, which will lead to improved health outcomes.

III. PROCEDURE

A. CalOptima shall conduct provider education and provide technical assistance to improve provider accuracy and completeness of clinical documentation.

B. By March of each Service Year, subject to Board approval of the continuation of the Primary Care Engagement and Clinical Documentation Integrity Program and related funding, CalOptima shall provide to each Qualified Provider via facsimile, U.S. mail or CalOptima provider portal, an attestation and Medical Records submission instruction documents for each of their assigned Members.

C. Upon completion of a face-to-face visit with a Member, the Qualified Provider shall affirm, negate or provide additional information, as appropriate, regarding the individualized HEDIS preventive care measures and health conditions on the attestation document. All face-to-face visits must be completed in the time period required by Service Year.

D. The Qualified Provider shall submit the verified attestation form, as well as supporting Medical Records to the CalOptima Quality Improvement Department via facsimile, U.S. mail or CalOptima provider portal when available, within the Submission Period, but no later than January 31 following the Service Year.

E. The Qualified Provider must appropriately document all of the required elements in the attestation form with supporting Medical Records, including, but not limited to:

1. Member name;

2. Date of service;

3. Preventive Medicine Screening section;

4. Year-Over-Year Conditions section;

5. Suspect Conditions (Pharmacy and/or Laboratory) section;

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6. Additional Conditions Present section;

7. Acceptable Qualified Provider signature with credentials; and

8. Date of authentication.

Note: For 4-6, condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10 Clinical Modification Guidelines for Coding and Reporting*.

F. Within thirty (30) calendar days from the end of the period submission month, the CalOptima Quality Improvement Department shall review the attestation form and supporting medical records to ensure each condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation. Upon receipt of Medical Records, CalOptima shall retain the Medical Records as set forth in CalOptima Policy GG.1603: Medical Records Maintenance.

G. In the event the CalOptima Quality Improvement Department determines that the attestation form or supporting medical record(s) is incomplete or lacking clinical justification, CalOptima staff will deny payment and provide written notification within thirty (30) calendar days to the Qualified Provider of the determination and rationale for the rejection.

H. CalOptima will remove and not submit any condition diagnosis codes to Centers for Medicare & Medicaid Services (CMS) that are not supported in the Medical Records to protect integrity of the process.

I. Upon receipt of CalOptima's notification of incomplete Medical Records, the Qualified Provider may dispute the findings within thirty (30) calendar days and resubmit the completed attestation form with corrected medical records.

J. In the event that the CalOptima Quality Improvement Department verifies the Qualified Provider has met the conditions as specified in Sections III.D and III.E. of this Policy, CalOptima shall make a supplemental payment of $150 per completed and verified attestation form with supporting Medical Records per Member per Qualified Provider per year.

1. CalOptima shall ensure per Member per Qualified Provider once a year payments are distributed to the Qualified Provider on a monthly basis.

2. CalOptima shall make supplemental payments within forty-five (45) calendar days from the end of the Submission Month.

K. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes, CalOptima may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance, as appropriate.

L. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records, and such issues negatively impact quality of care or service delivered to a Member, such matters may be referred as a Potential Quality Issue in accordance with CalOptima Policy GG.1611: Potential Quality Issues Review Process or refer to the Office of Compliance for further review and investigation depending on the nature and scope of the inaccurate reporting.

IV. ATTACHMENT(S)

A. 2020 Quality Attestation Form

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V. REFERENCE(S)

A. CalOptima Policy GG.1603: Medical Records Maintenance
B. CalOptima Policy GG.1611: Potential Quality Issues Review Process
C. CMS Medicare Managed Care Manual, IOM, Chapter 7
D. American Journal of Managed Care, "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs", March 8, 2019, https://www.ajmc.com/journals/issue/2019/2019-vol25-n3/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs
E. Journal of Primary Care & Community Health, "The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening", October 08, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932741/
F. 42 CFR Section 422.310

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	CMC.2001	Primary Care Engagement and Clinical Documentation Integrity Program	OneCare Connect

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IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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 the CalOptima OneCare Connect program.
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Primary Care Engagement and Clinical Documentation Integrity Program	A program to improve member engagement with their primary care provider (PCP) and clinical documentation accuracy and completeness in Qualifying Medical Records. CalOptima shall provide PCP's an attestation form listing quality measures and condition diagnosis codes for each of their assigned members for clinical validation during a face-to-face visit. The provider shall be responsible for completing the attestation form and returning the form along with supporting clinical documentation to CalOptima.
Qualified Provider(s)	For purposes of this policy, contracted Primary Care Provider (PCP), or, when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Service Year	January 1 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation is submitted to CalOptima.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).

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2020 Quality Attestation Form

Patient: Doe, John

Member ID: **99999999A** DOB: **01/01/1900**

Date(s) of Service: _____

Provider Information

Check Box to confirm the provider completing the assessment. Enter the provider name and NPI if not populated.

☐ Provider: **Doe, Jane**
☐ Provider: _____

Preventive Care Screening

Screening to Consider	Date Completed	Date Ordered	Date Member Declined or Provider Refused
Body Mass Index (BMI & Weight Required)	_____	_____	_____
Colorectal Cancer Screening	_____	_____	_____

Year Over Year Conditions

Potential Diagnosis	Diagnosis Code	Risk Factor	Present	Not Present	Unable to Determine
Type 2 diabetes mellitus without complications	E11.9	Diabetes without Complication	☐	☐	☐
Cardiomyopathy, unspecified	I42.9	Congestive Heart Failure	☐	☐	☐
Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side	I69.351	Hemiplegia/ Hemiparesis	☐	☐	☐

Suspect Conditions (Pharmacy and/or Laboratory)

Risk Factor	Diagnosis Code	Present	Not Present
Ischemic or Unspecified Stroke	_____	☐	☐
Unstable Angina and Other Acute Ischemic Heart Disease	_____	☐	☐

Additional Conditions Present

Diagnosis Code	Date(s) of Service	Present
_____	_____	☐

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2020 Quality Attestation Form

_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐

Provider Signature

Under penalty of perjury, I hereby attest that the above information is accurate and complete based on a face-to-face encounter with the member, which is fully documented in the medical record.

Signature: _____ Date: _____

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OneCare Connect

CalOptima

A Public Agency

Better. Together.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Primary Care Engagement and Clinical Documentation Integrity Program

Board of Directors Meeting
May 7, 2020

David Ramirez, M.D., Chief Medical Officer
Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

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OneCare Connect (OCC) Community Care Network (CCN) Members

Medicare Data Submission and Risk Adjustment

- CalOptima is required to regularly submit diagnosis data to Centers for Medicare & Medicaid Services (CMS) for OCC members
  - The source of CalOptima's diagnosis data is from encounters and chart review
  - Currently, health networks (HN) are obligated to submit timely and accurate data
- CMS uses this data to assess program quality and to calculate revenue
  - Healthcare Effectiveness Data and Information Set (HEDIS) quality measures are used to determine annual Medicare Star Ratings
  - CMS calculates CalOptima's revenue by multiplying the base rate by a risk score
    - The risk score is used to reflect the acuity within the OCC membership population

Medicare Attestation Programs

- Medicare Attestation Programs
  - Improve quality and member care
    - Increase access to preventive services
    - Increase identification of members who may benefit from enhanced care coordination
  - Improve timeliness and accuracy of Individual Care Plans
  - Improve completeness, timeliness and accuracy of information submitted to CMS and National Committee for Quality Assurance (NCQA)

Comparison of CCN and HNs: Risk Adjustment Factors (RAF)

RAF Score Comparison (Calendar Year 2019)

Delegation Assignment	Member Month	Average RAF	No Claims	No HCCs	Dropped HCCs
CCN	**10,607**	**1.180**	**949**	**2,965**	**4,043**
HNs	89,830	1.431	8,460	22,112	29,029

- CCN's average RAF is 17.54% (0.251) below the HN average
- CCN has 185 PCPs; 138 also working with another HN

HCC: Hierarchical Condition Category

Comparison of CCN and HHs: RAF (cont.)

Inpatient Day Utilization (1000 members/year) vs. RAF

Risk	Member Months	RAF	Inpatient Days PTMPY	RAF Based on I/P Risk	RAF Difference
CCN	10,607	**1.180**	141.81	**1.921**	**-0.741**
SRG	33,418	1.241	86.24	1.168	0.073
PHC	3,371	0.922	102.47	1.388	-0.466
HMO	53,041	1.582	107.09	1.451	0.132
TOTAL	100,437	1.404	103.66	1.404	**0.000**

- Using Inpatient Day Utilization per thousand members per year (PTMPY) as a determinant of risk within a HN, the underlying risk within CCN far exceeds the reported RAF score

Proposed Attestation Program: Goals and Incentive Requirements

- Document that identifies Quality measures and HCC and diagnosis (Dx) codes that need to be addressed by the primary care provider (PCP)

- Goals
  - Increase PCP outreach to members for annual visits
  - Review charts in real time rather than retrospective
  - Improve year-over-year HCC recapture rate
  - Increase newly identified Dx/HCC

- Incentive Requirements
  - All codes must be addressed
  - Supporting documentation must be submitted (medical chart)
  - Coder review of attestation and chart for accuracy
  - Visit must be completed in the calendar year

Proposed Attestation Program: Benefits

- Benefits
  - Improve overall member care
  - Improve quality measures
  - Improve accuracy of population acuity
  - Improve resulting risk scores

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Actions Related to Supporting Orange County Nursing Facilities During the Coronavirus (COVID-19) Pandemic

Contact

Emily Fonda, M.D., MMM CHCQM, Deputy Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, RN, CCM, Executive Director Clinical Operations (714)246-8400

Recommended Actions

1. Authorize the CEO, with the assistance of Legal Counsel, to enter into a Grant Agreement with the Regents of the University of California at Irvine (UCI) to provide funding to support the Orange County COVID Nursing Home Prevention Program, contingent upon equal financial participation from the Orange County Health Care Agency (OCHCA); and
2. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds in the amount not to exceed $629,723 to support the Orange County COVID Nursing Home Prevention Program.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42U.S.C.247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside of a list of "essential activities." These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops.

On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus.

The California Department of Public Health, recognizing that individuals residing in nursing facilities are among the most vulnerable to infection and serious illness due to COVID-19 has issued guidance to the skilled nursing facilities (SNFs) to limit transmission of the virus, which includes mandated reporting of COVID 19 positive residents and preparation for grouping these residents into cohorts.

In order to help mitigate the spread in congregate living facilities, CalOptima modified its Post-Acute Infection Prevention (PIPQI) program, originally approved by the CalOptima Board of Directors (Board) on June 6, 2019, to increase the number of participating facilities and provide flexibility in the program due to social distancing. Specifically, on April 2, 2020 the Board approved allocation of IGT 9

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funds in the area of Quality Performance specifically to support continuation and expansion of the PIPQI program. At that time, $4.5 million remained allocated towards member access and engagement initiatives. Additionally, on April 16, 2020, the Board approved modifications to the PIPQI program during the COVID-19 crisis, suspending skin testing to confirm the presence of CHG and allowing early disbursement of incentive payments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR).

Unfortunately, the COVID-19 pandemic continues to have a deleterious effect on congregate living facilities in other states as well as within Orange County. As of April 22, 2020, Orange County has four nursing facilities reporting residents and/or staff who are COVID-19 positive, some of whom are hospitalized, and three residents who have expired. As a result, CalOptima, in partnership with the OCHCA, are exploring new options to decrease the spread of COVID-19 in the community.

At the April 2, 2020, meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

Discussion

UCI has been actively pursuing methods to combat the spread of COVID-19. Susan Huang, MD, MPH, Professor, Division of Infectious Diseases and Medical Director, Epidemiology & Infection Prevention established a project to develop a toolkit and implementation training to improve prevention, readiness and restrict, to the extent possible, the impact of the anticipated COVID-19 surge to Orange County nursing homes and the local systems of care.

The primary goals of the Orange County COVID Nursing Home Prevention Program developed by UCI include:

1. Engaging nursing homes to undergo intensive COVID-19 infection prevention training to provide greater depth and assurance of infection prevention readiness in a key subgroup that can serve as a high-fidelity resource; and
2. Supporting serologic and point prevalence PCR testing of residents and staff in select nursing homes to inform trajectory toward spread and immunity.
3. Developing a toolkit and implementation training to improve the infection prevention readiness for COVID-19 surge across OC nursing homes;

The project includes collaboration with OCHCA and leveraging their efforts in developing the local public health response to clusters and cases in SNFs, as well as incorporating CDC and public health guidance. CalOptima's PIPQI program was developed as a means of infection prevention by replacing liquid soap with Chlorhexidine (CHG) soap for bathing and using Iodophor nasal swabs every other week. As a result of the program, long-term residents in program-participating facilities showed

markedly lower rates of Multi Drug Resistant Organism (MDRO) colonization and lower rates of hospital admissions due to infection and lower utilization costs for CalOptima members. The PIPQI program includes outreach and engagement, establishment of protocols, facility staff training, and quality testing. The UCI COVID Nursing Home Prevention Program will operate concurrently and build upon training and successes realized through CalOptima's PIPQI program.

Funding for the project requires a $629,723 contribution each from OCHCA and CalOptima. Staff recommends an allocation of $629,723 in IGT 9 funding under the Board-approved focus area of member access and engagement to support this project. OCHCA and CalOptima worked in partnership with UCI to align the project goals, deliverables, and funding schedules.

Fiscal Impact

The recommended action to ratify the grant agreement with UCI to provide funding to support the Orange County COVID Nursing Home Prevention Program has no net fiscal impact to CalOptima's operating budget. Staff estimates that IGT 9 revenue from the California Department of Health Care Services will be sufficient to cover the allocated expenditures for the recommended project.

Rationale for Recommendation

The recommended actions will support CalOptima's efforts to continue providing quality healthcare to members residing at SNFs during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Initiative and authorize Quality Incentive Payments
3. CalOptima Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
4. CalOptima Board Action dated April 16, 2020, Consider Authorizing Modifications to the Post-Acute Infection Prevention Quality Initiative During the Coronavirus Disease (COVID-19) Crisis

/s/ Richard Sanchez — *04/29/2020*

Authorized Signature — **Date**

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Attachment 1 to May 7, 2020 Board of Directors Meeting – Agenda Item 7

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Regents of the University of California at Irvine	120 Theory, Suite 200	Irvine	CA	92697-1050

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

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

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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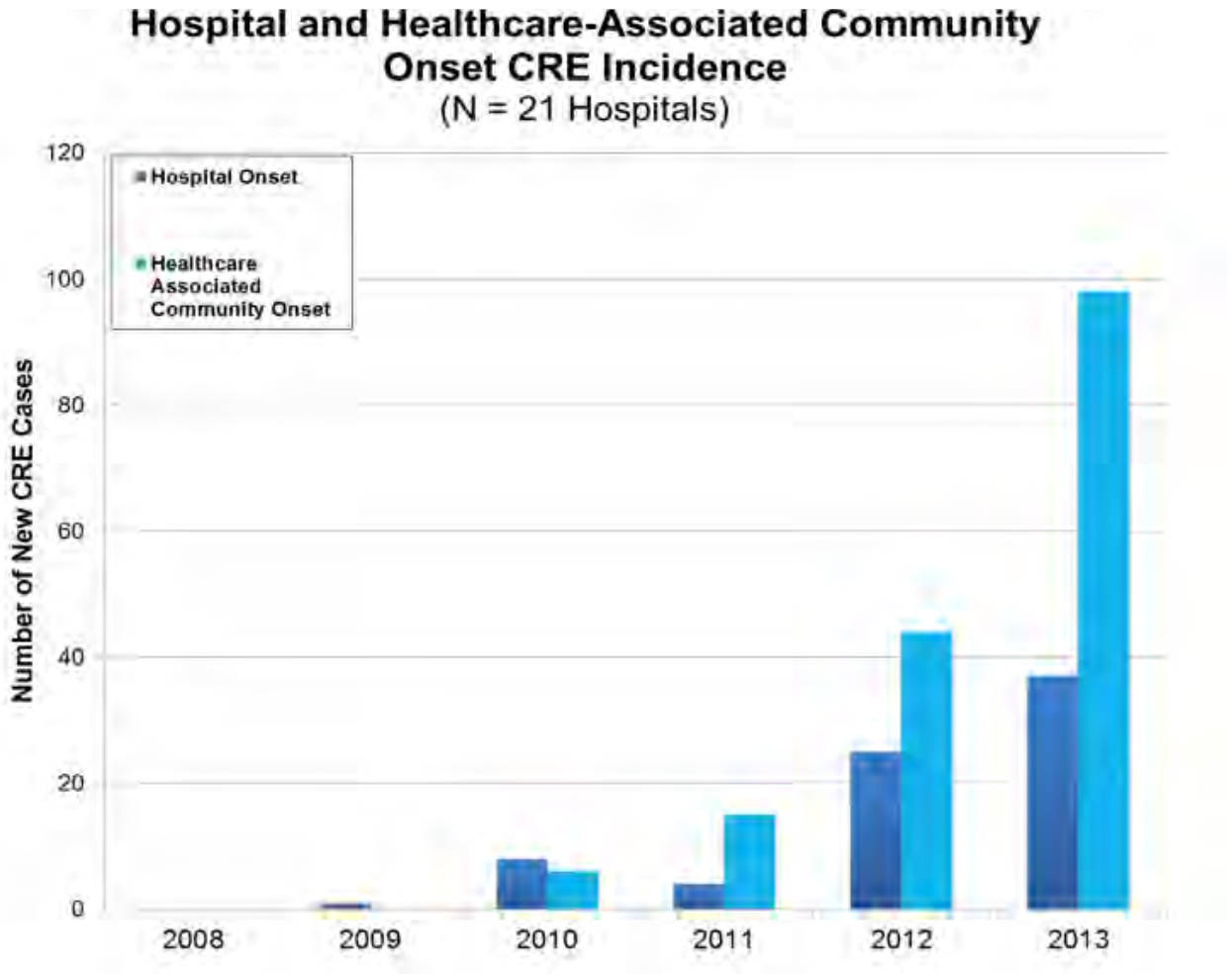
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

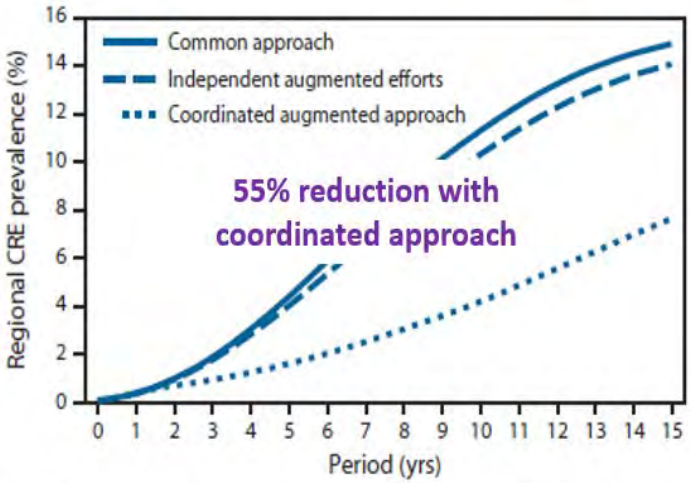
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[8]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*

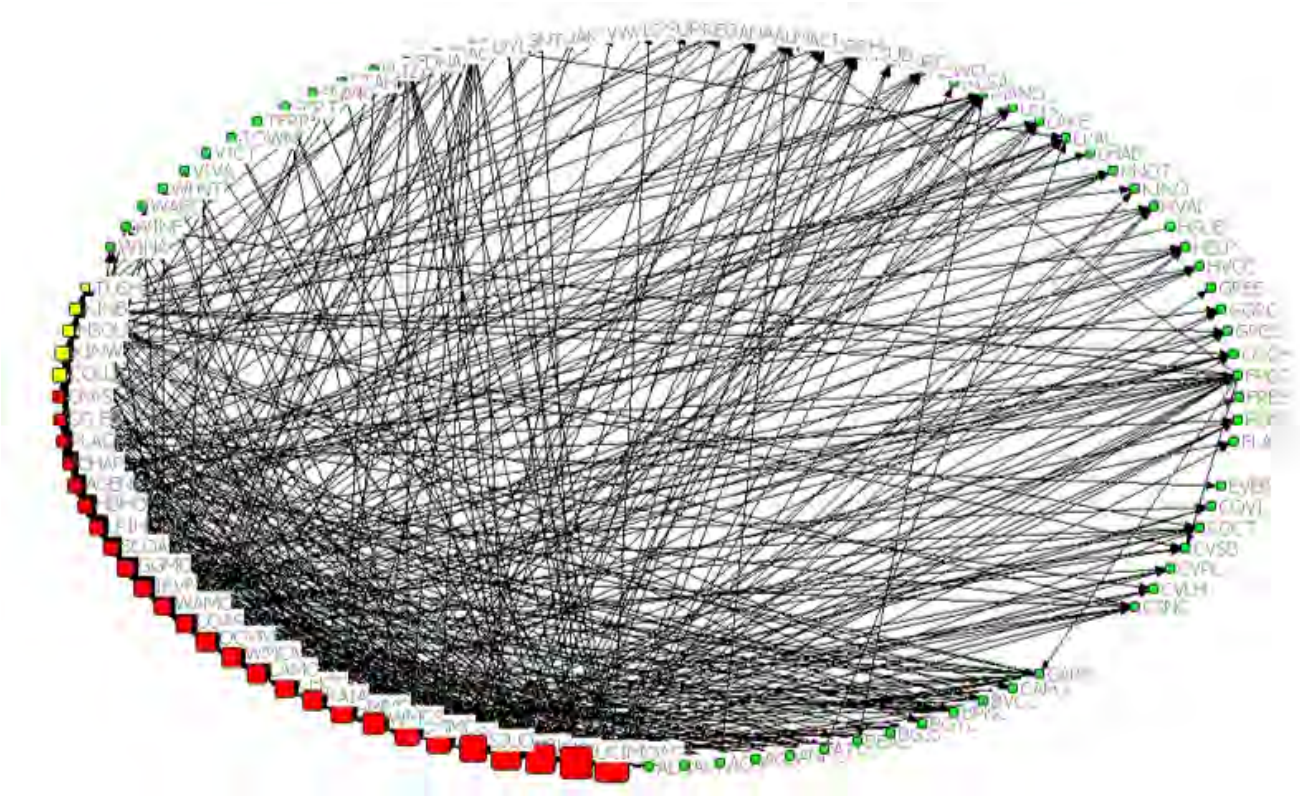


* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

Extent of the Problem

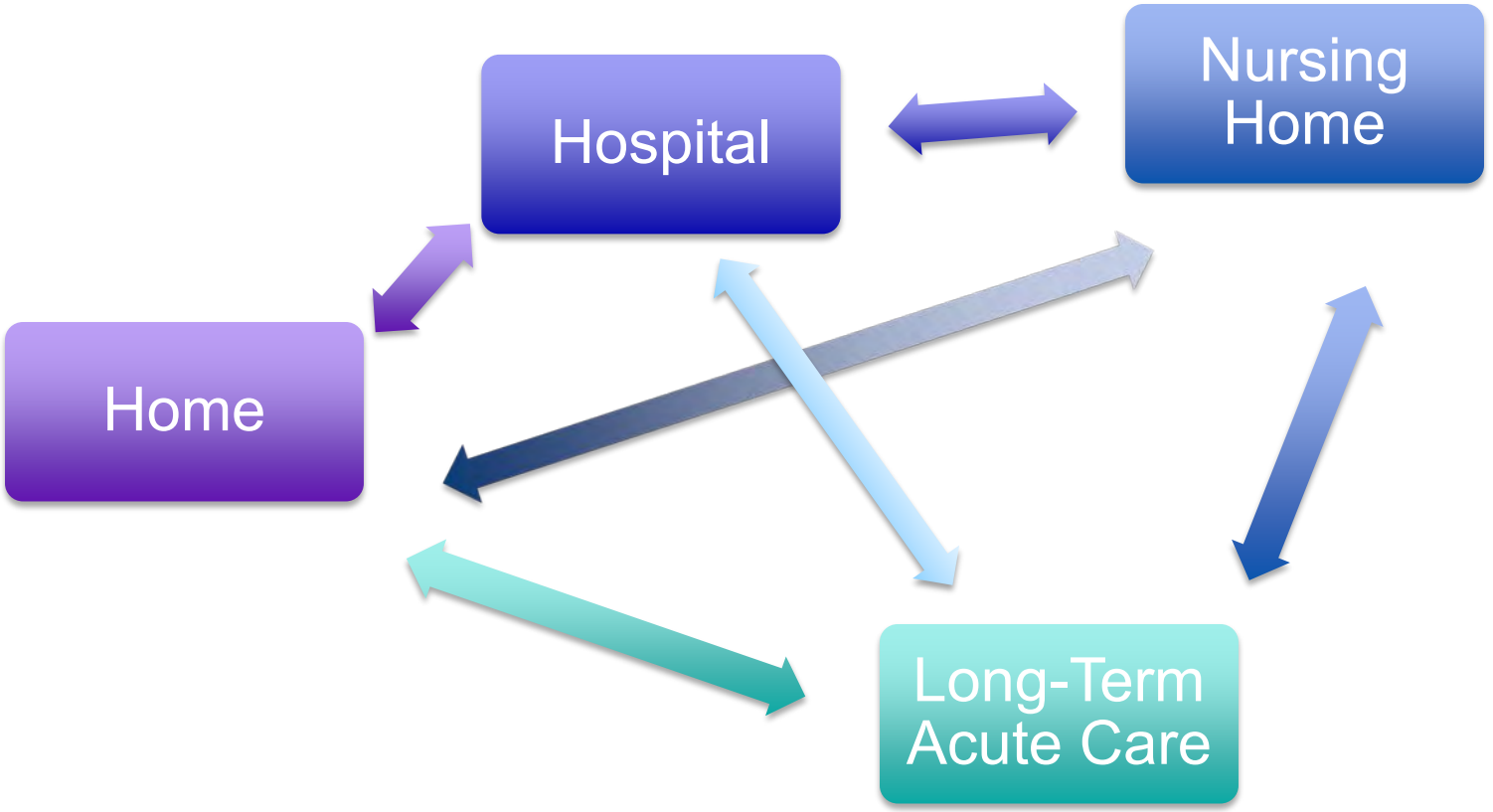
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

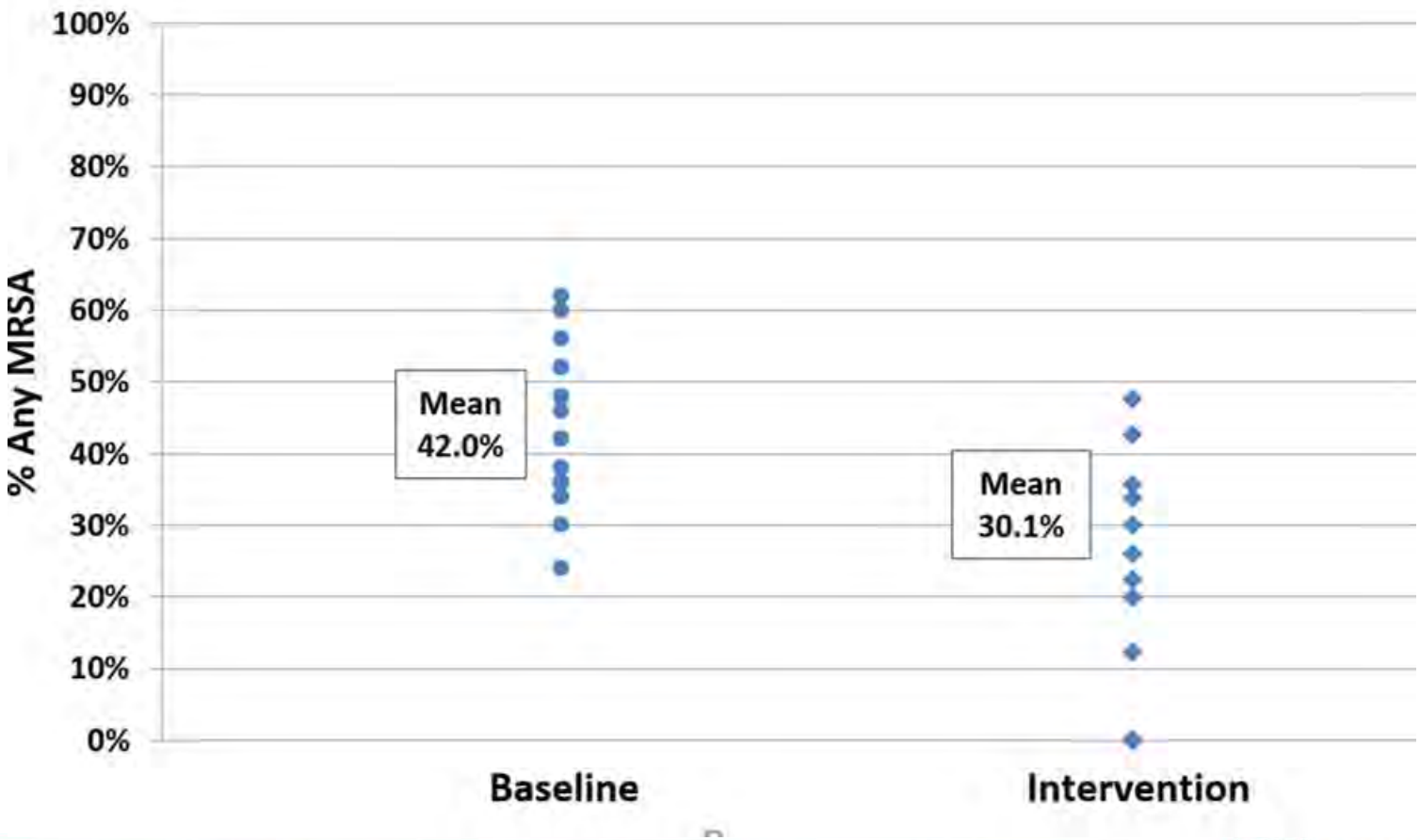
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



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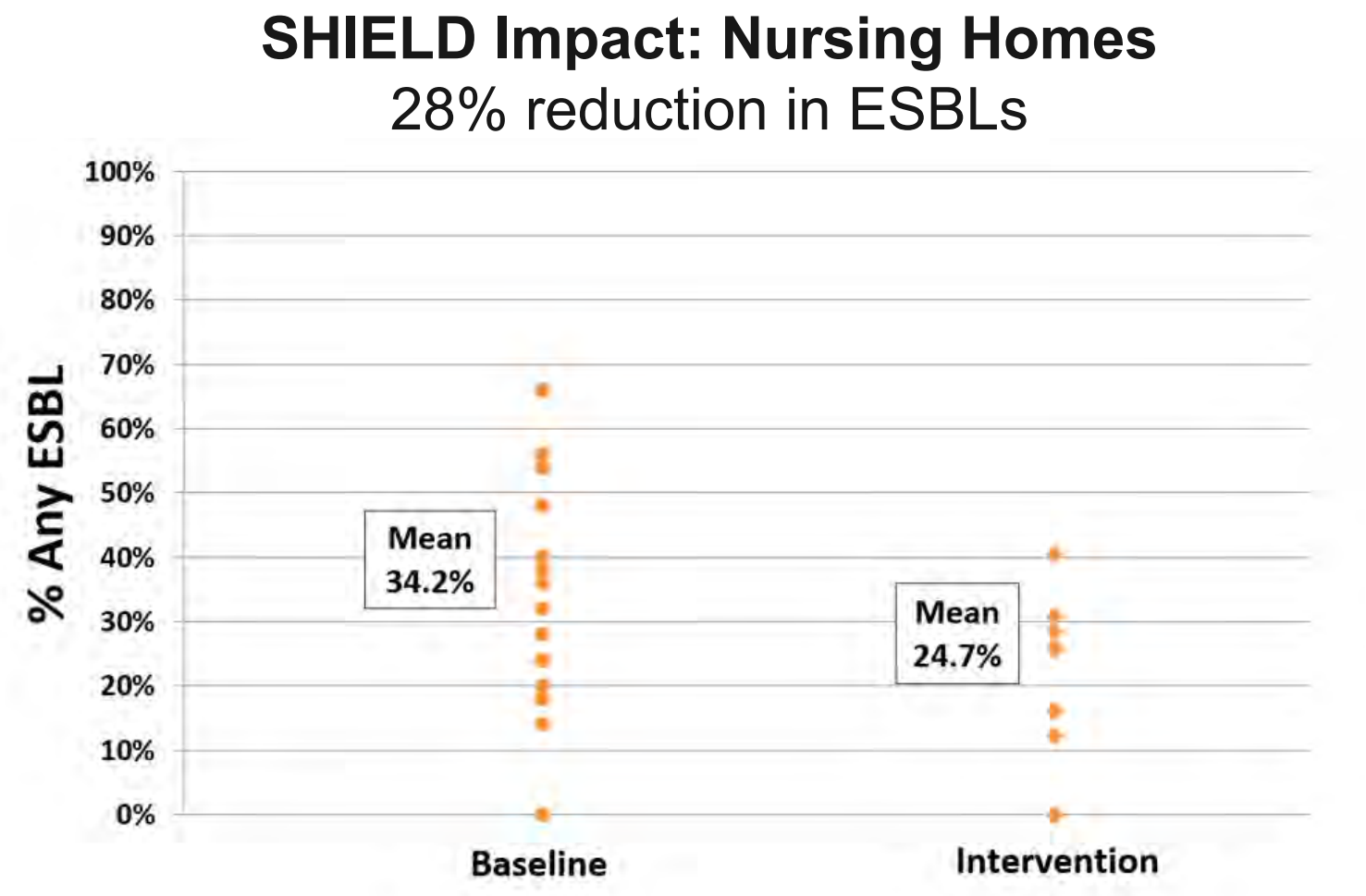
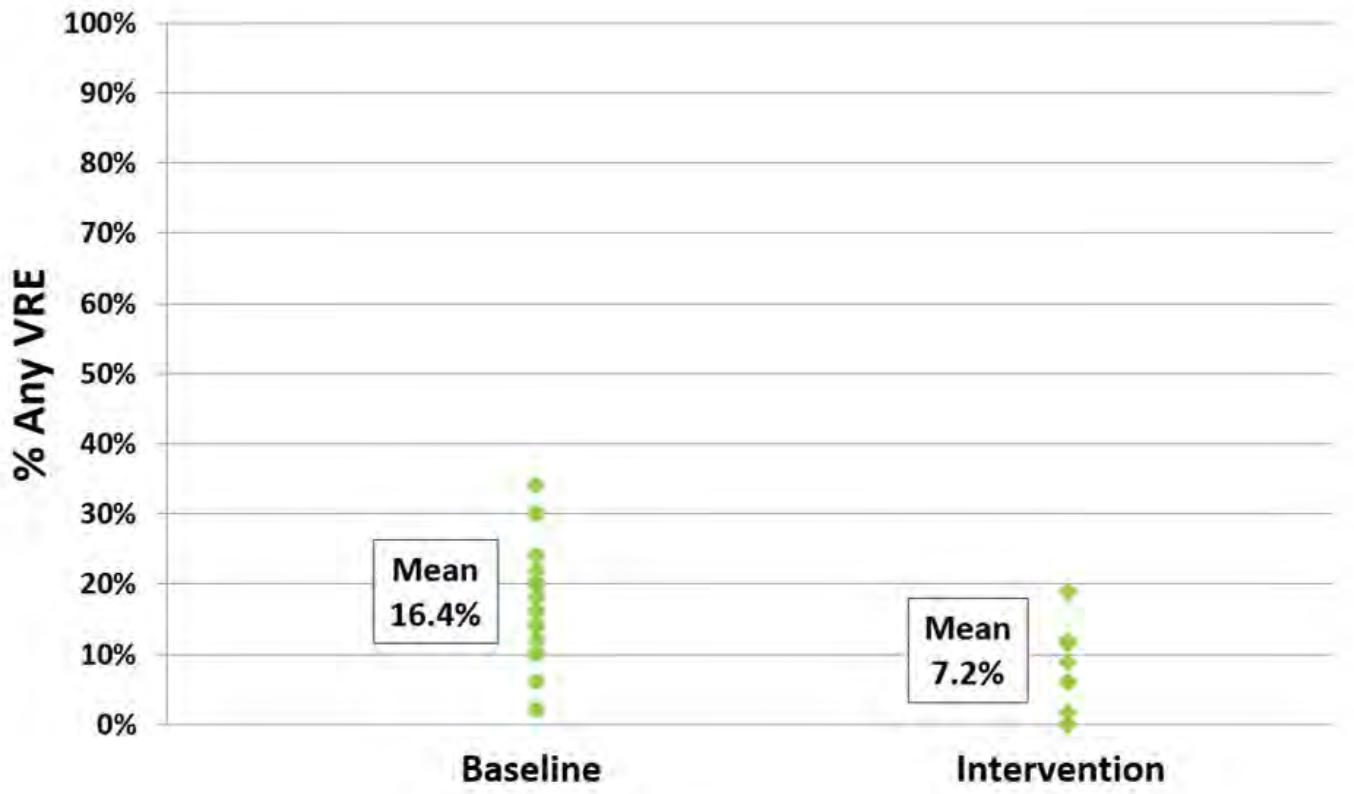
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

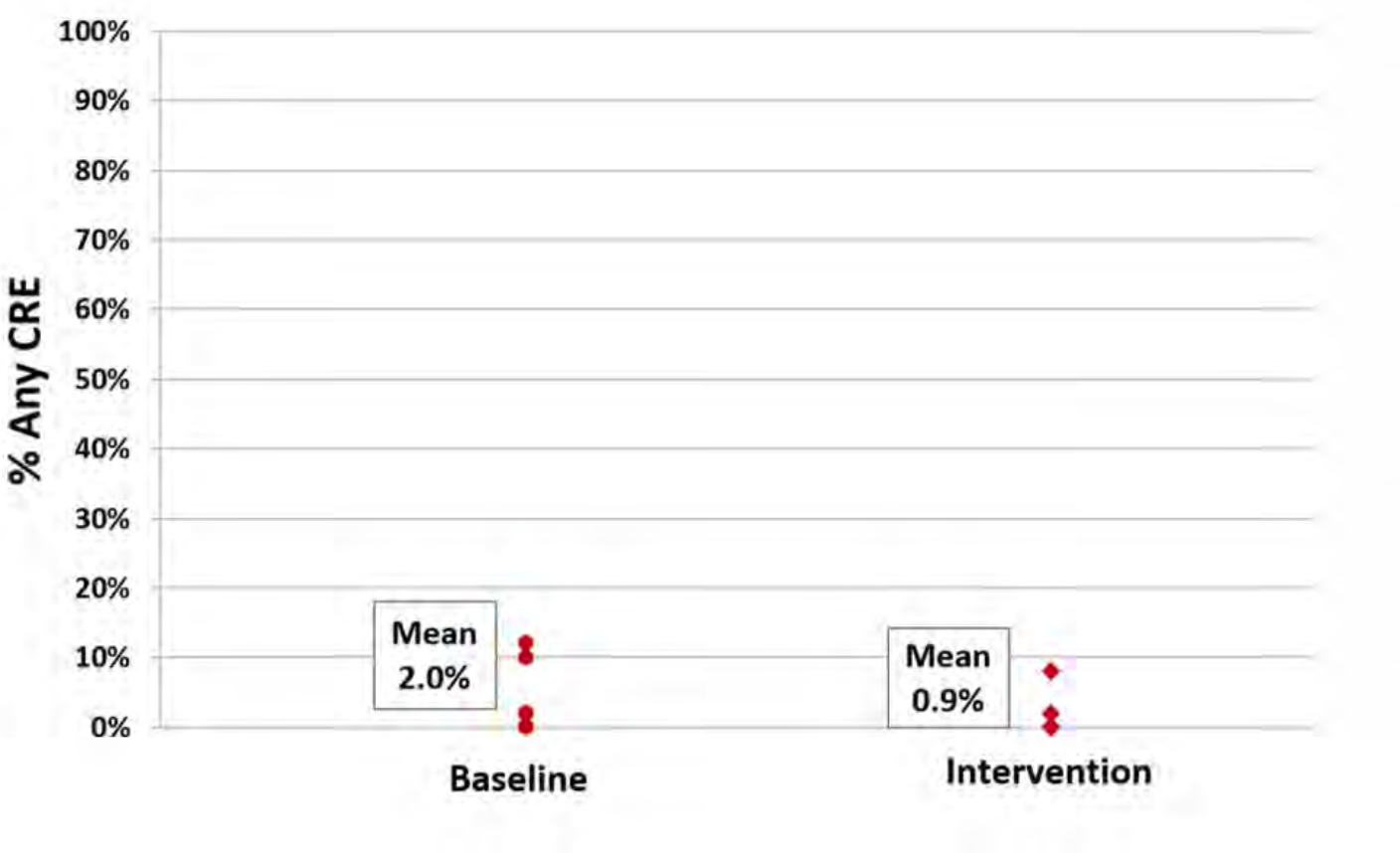
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

55% reduction in CRE



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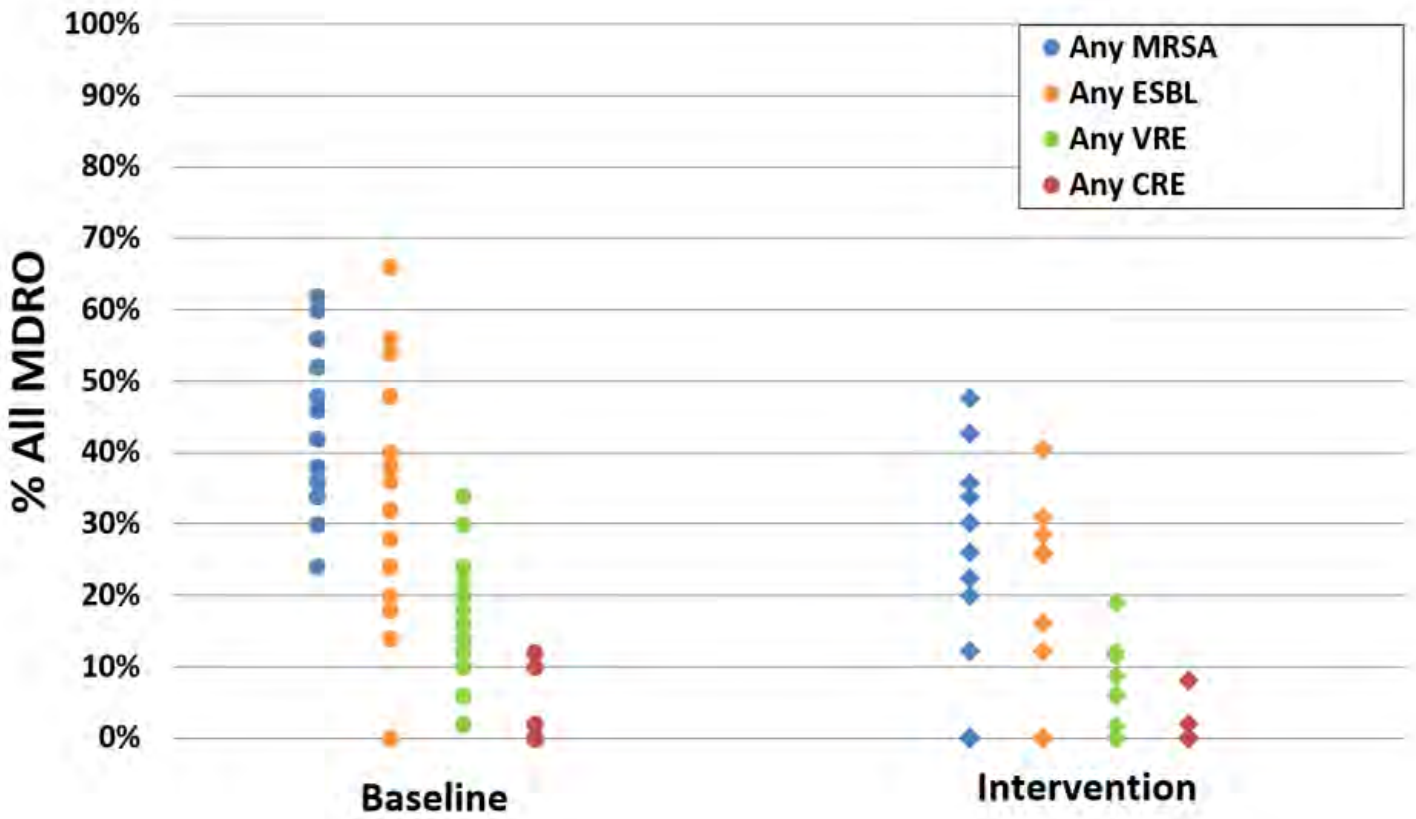
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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CalOptima A Public Agency Better. Together.

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team
(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Huang at the University of California Irvine School of Medicine, Division of Infectious Diseases, 100 Theory, Suite 120, Irvine, CA 92617, or at sshuang@uci.edu.

N Engl J Med 2019;380:638-50.
DOI: 10.1056/NEJMoa1716771

Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

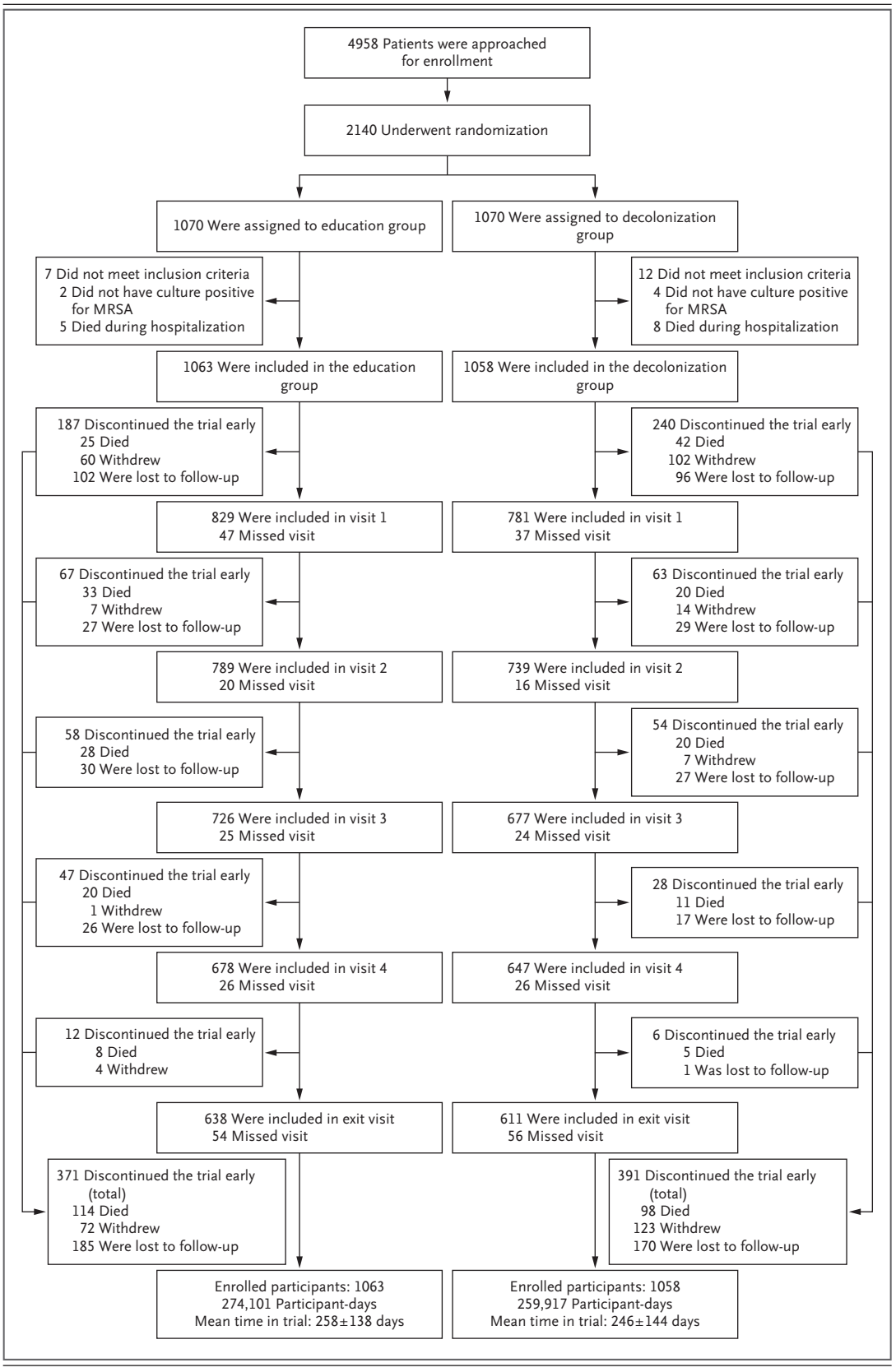

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

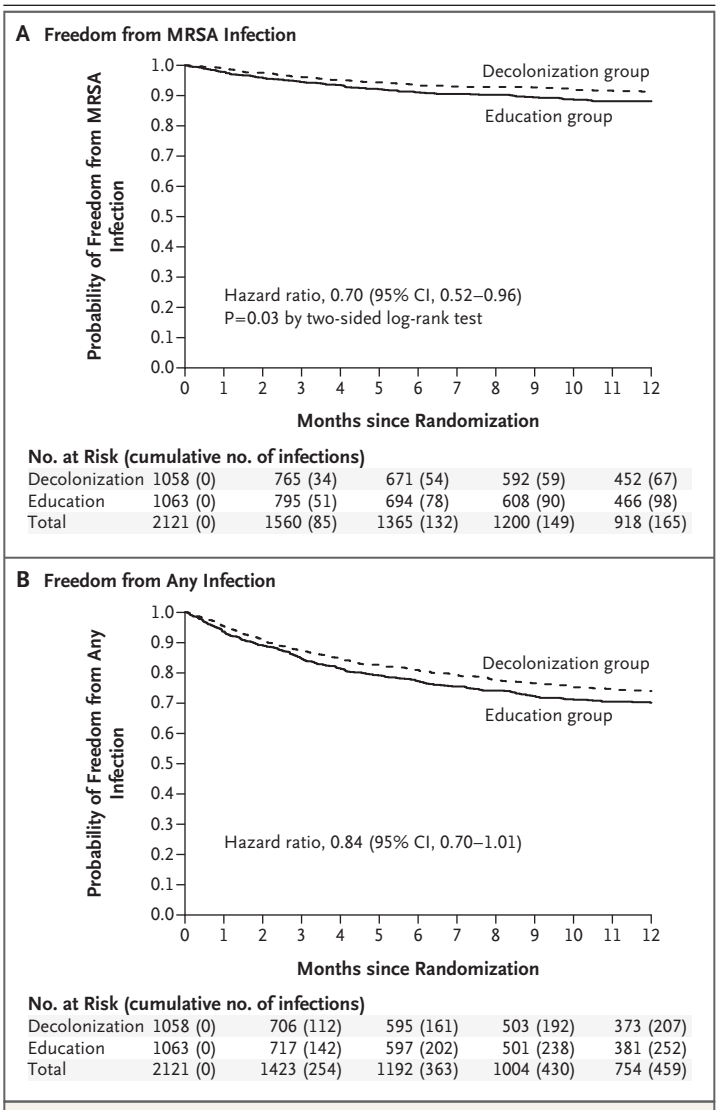

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

The authors' full names and academic degrees are as follows: Susan S. Huang, M.D., M.P.H, Raveena Singh, M.A., James A. McKinnell, M.D., Steven Park, M.D., Ph.D., Adrijana Gombosev, M.S., Samantha J. Eells, M.P.H., Daniel L. Gillen, Ph.D., Diane Kim, B.S., Syma Rashid, M.D., Raul Macias-Gil, M.D., Michael A. Bolaris, M.D., Thomas Tjoa, M.P.H., M.S., Chenghua Cao, M.P.H., Suzie S. Hong, M.S., Jennifer Lequieu, B.S., Eric Cui, B.S., Justin Chang, B.S., Jiayi He, M.S., Kaye Evans, B.A., Ellena Peterson, Ph.D., Gail Simpson, M.D., Philip Robinson, M.D., Chester Choi, M.D., Charles C. Bailey, Jr., M.D., James D. Leo, M.D., Alpesh Amin, M.D., Donald Goldmann, M.D., John A. Jernigan, M.D., Richard Platt, M.D., Edward Septimus, M.D., Robert A. Weinstein, M.D., Mary K. Hayden, M.D., and Loren G. Miller, M.D., M.P.H.

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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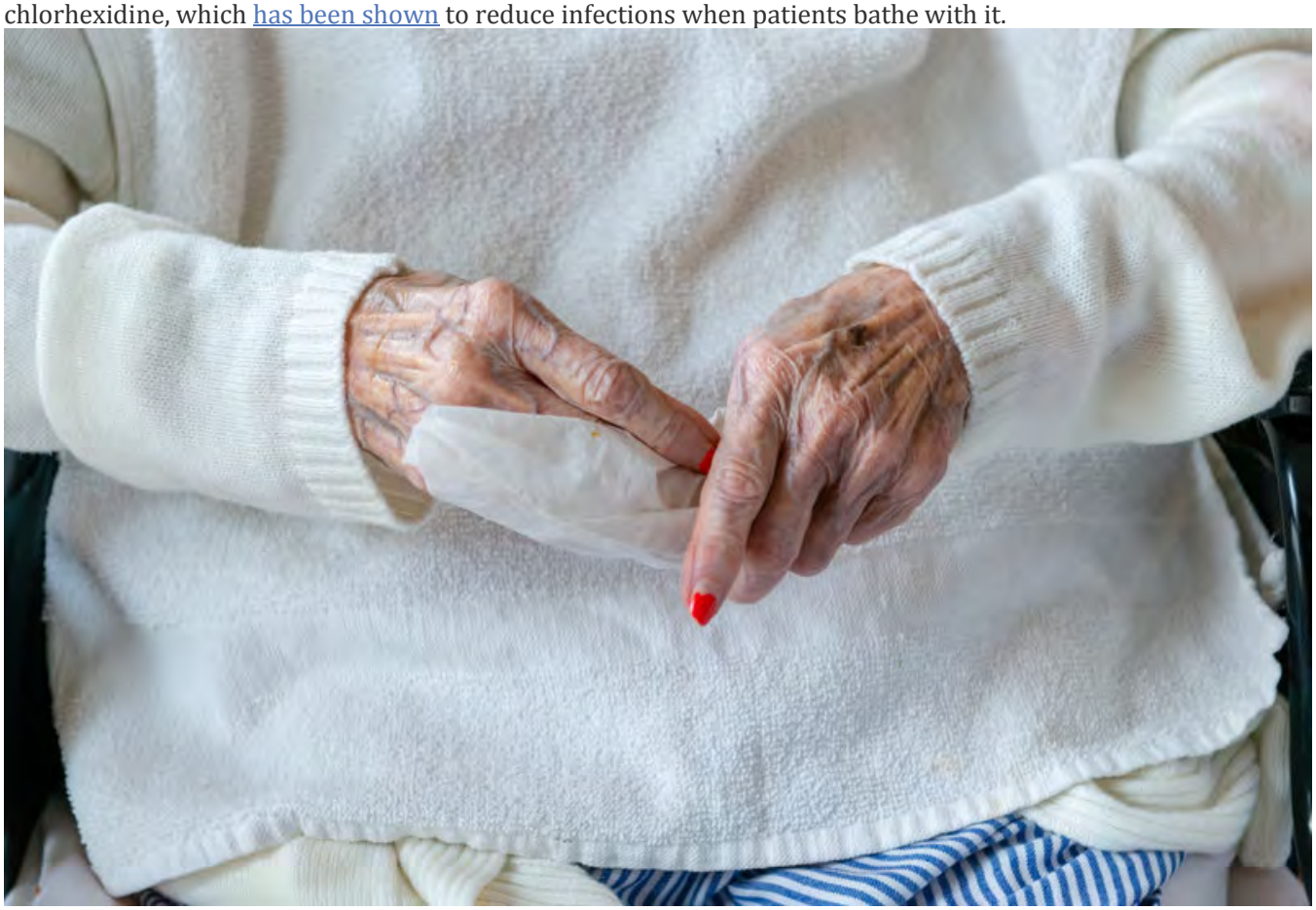
"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.



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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says**.** "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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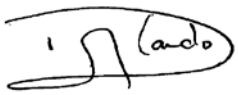
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
    a. Additional initiative(s) related to member access and engagement; and
    b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

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Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees' recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program's financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting $40.5 million of the anticipated $45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million

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4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee
Board of Directors' Quality Assurance Committee

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

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CalOptima
A Public Agency
Better. Together.

Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting
April 2, 2020

David Ramirez, M.D., Chief Medical Officer
Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

Proposed Allocation and Initiatives

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. W hole Child Model Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

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services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact
The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation
Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *8/29/2018*
Authorized Signature — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

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2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

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uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

Total	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

   If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

   (i) The name of the entity transferring funds:

   (ii) The operational nature of the entity (state, county, city, other):

   (iii) The source of the funds:
   (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

   (iv) Does the transferring entity have general taxing authority? *(Yes / No)*

   (v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.
[2]Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

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

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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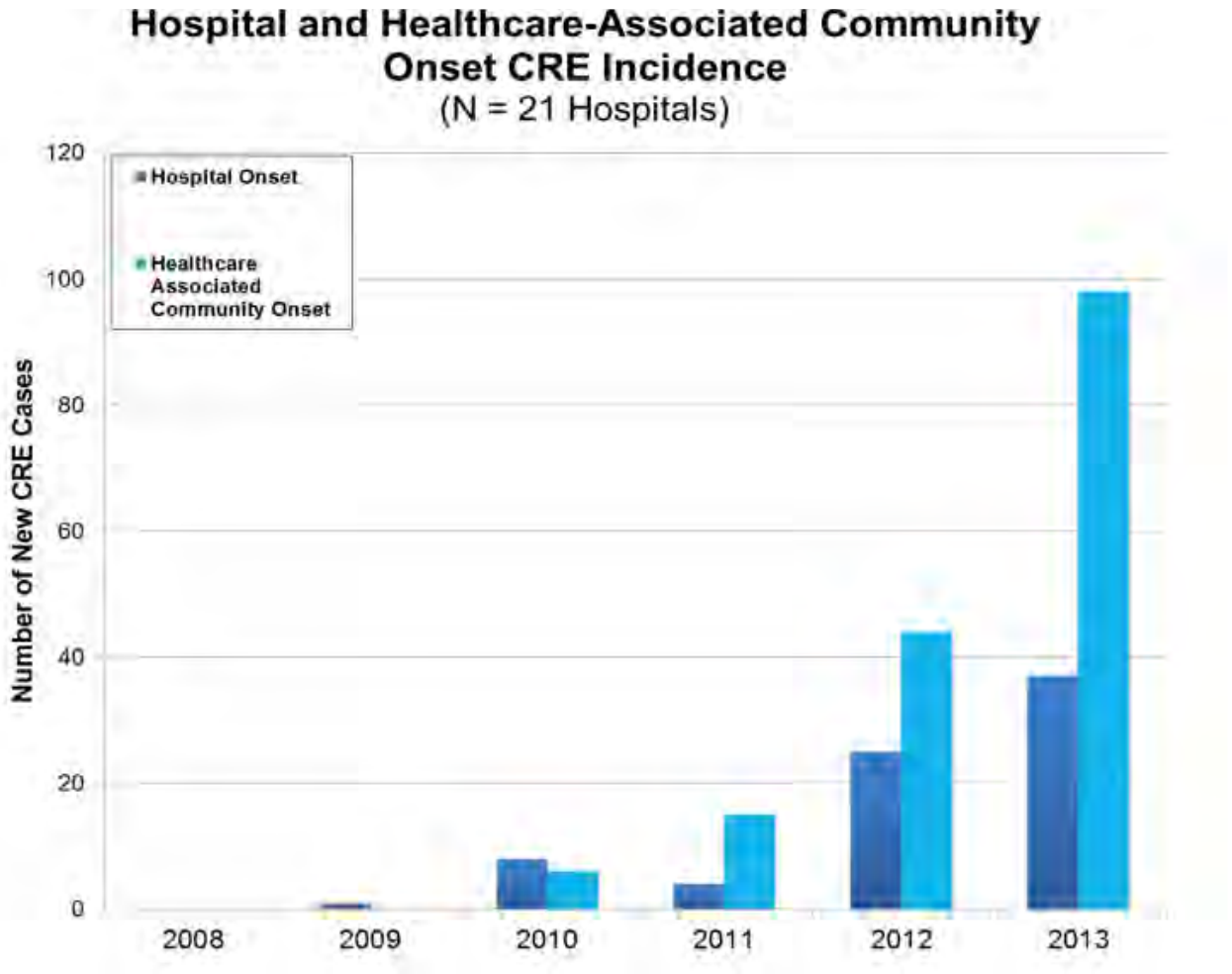
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

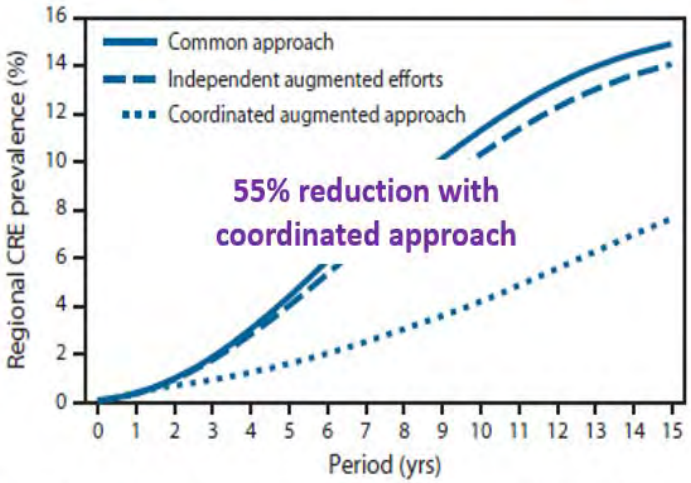
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[8]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*

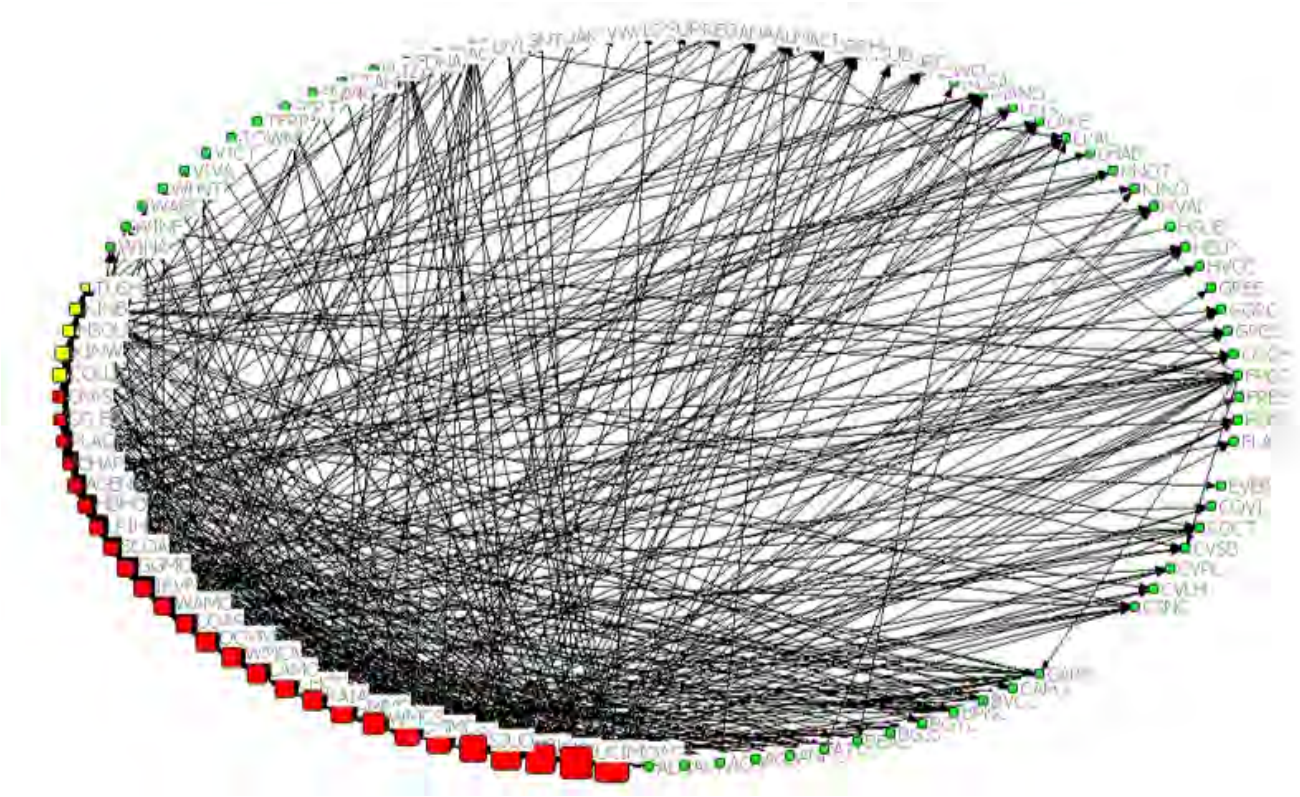


* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

Extent of the Problem

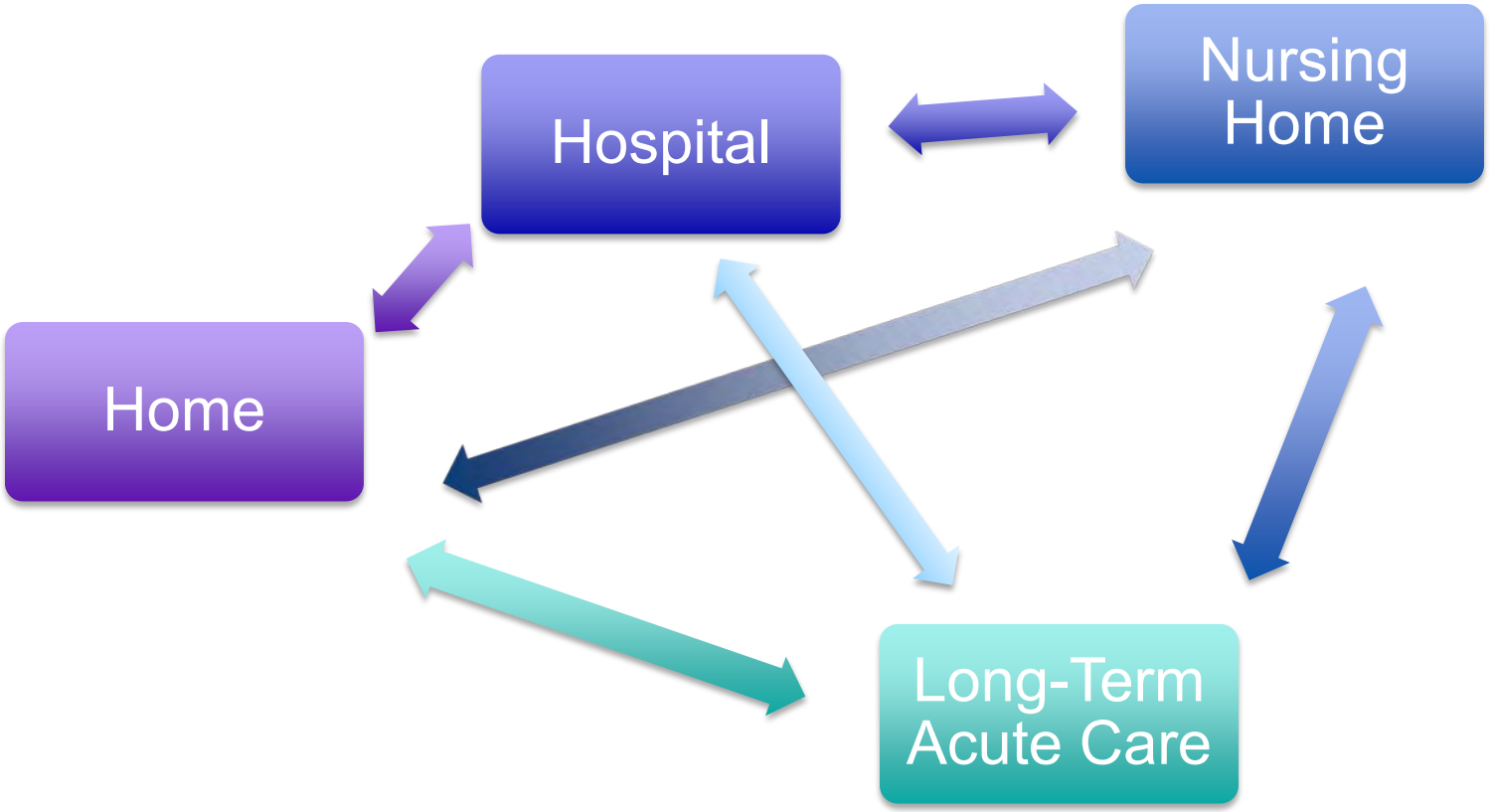
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

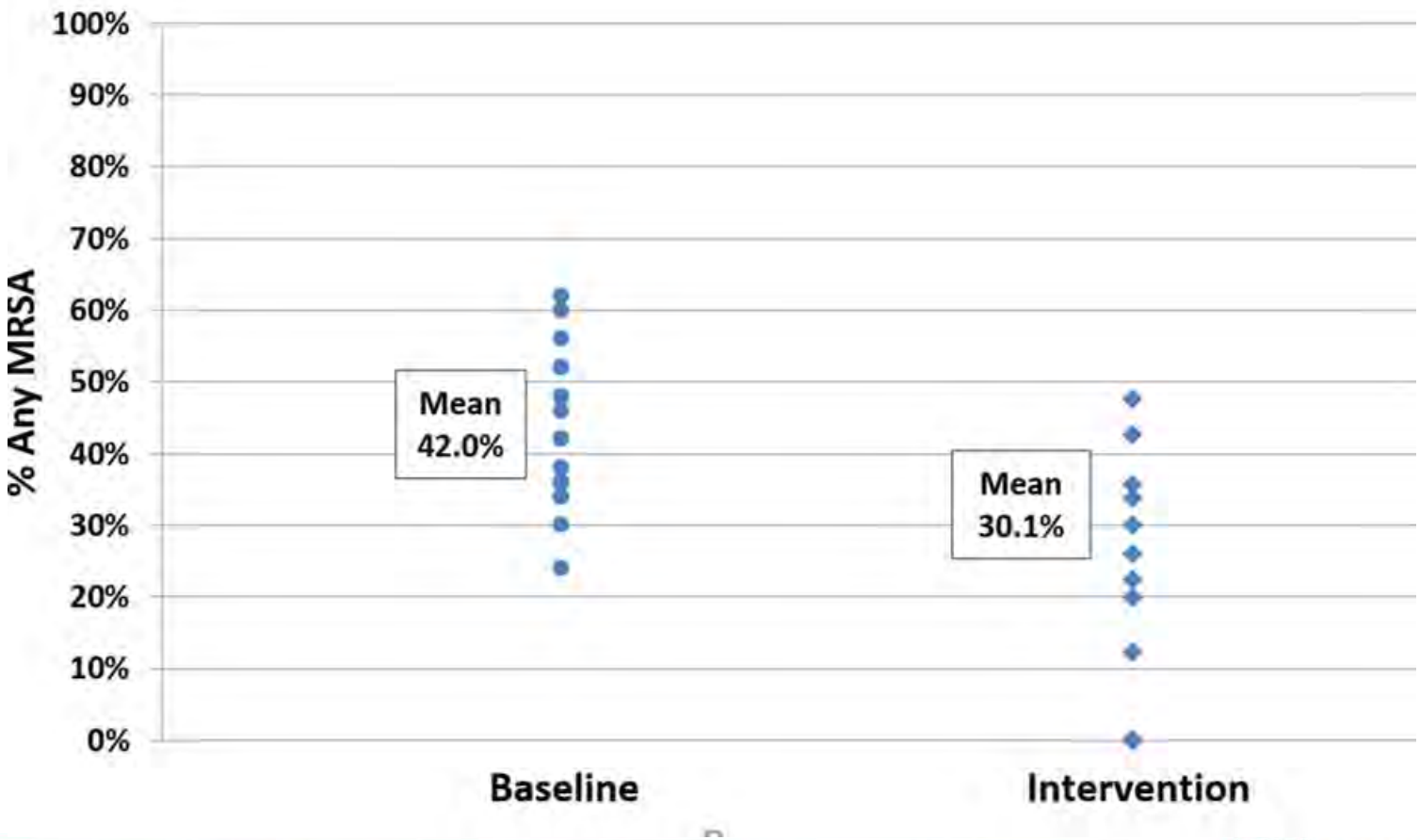
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



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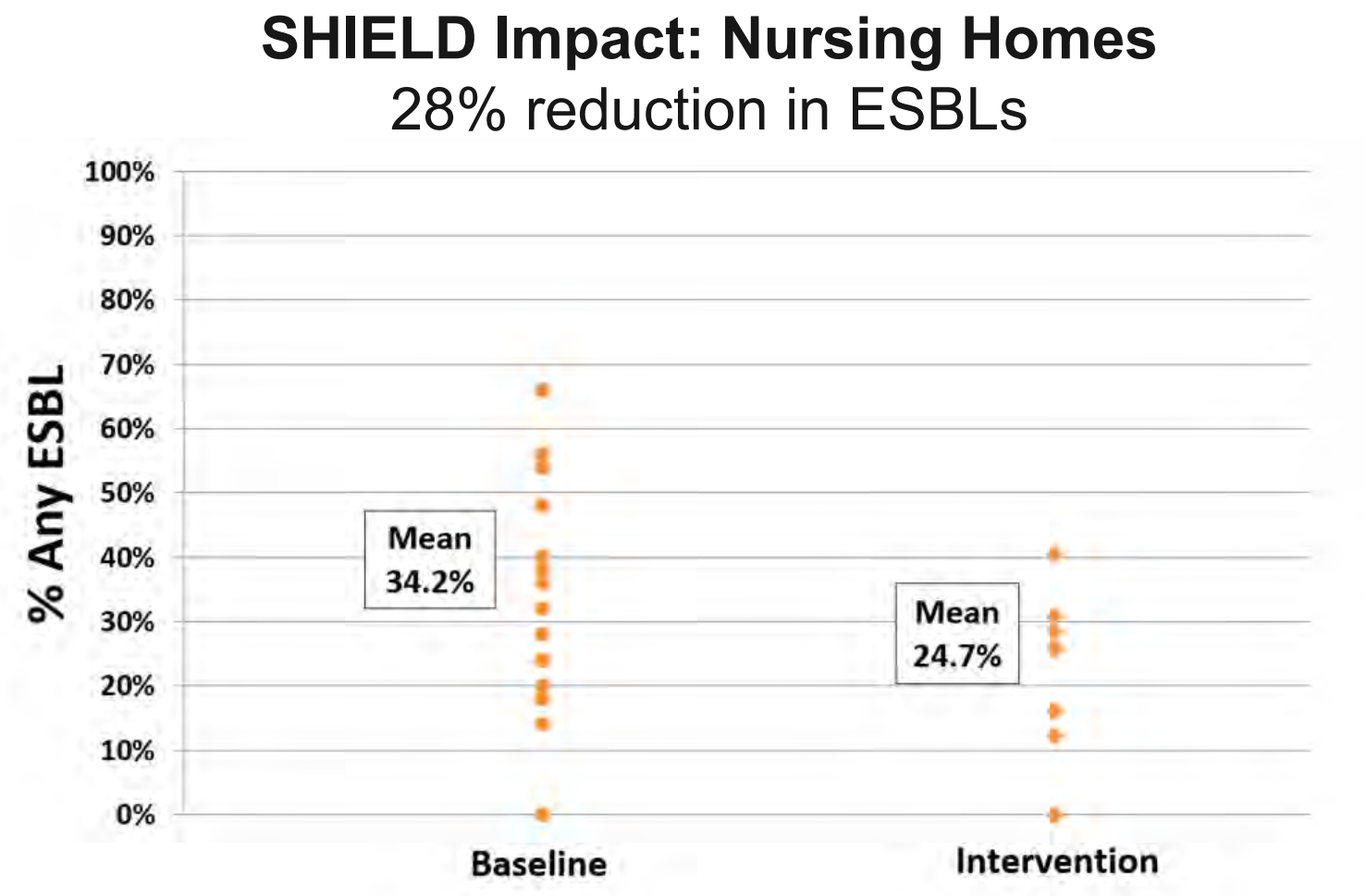
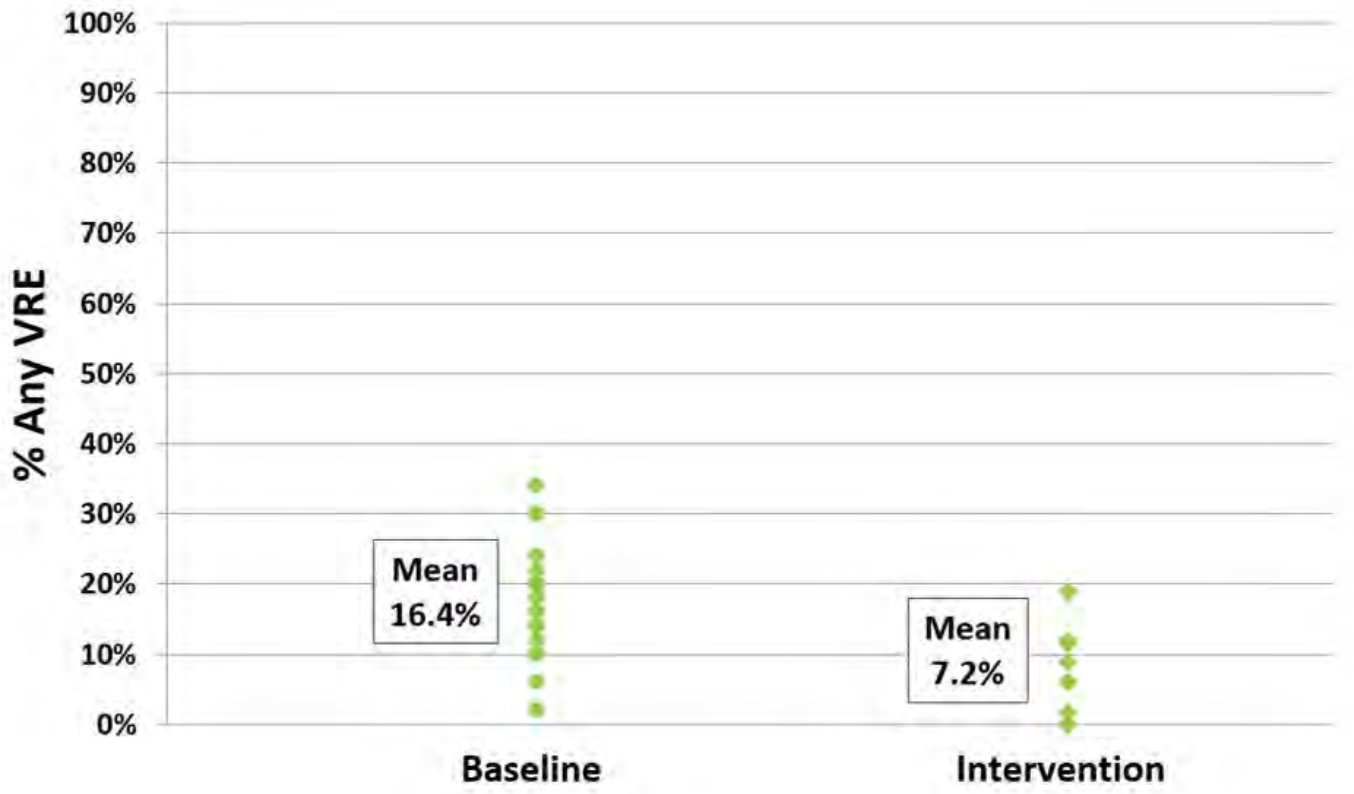
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

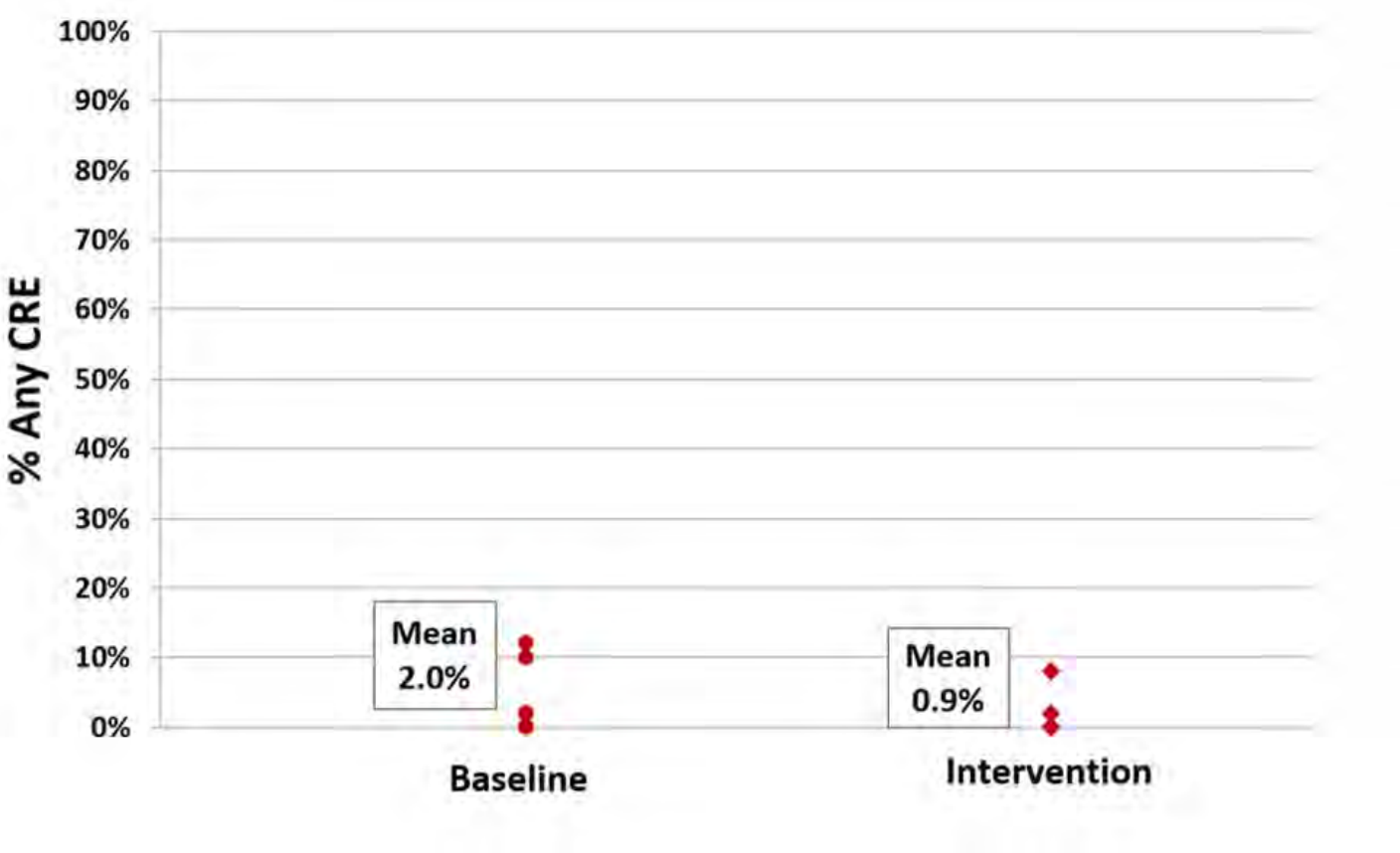
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

55% reduction in CRE



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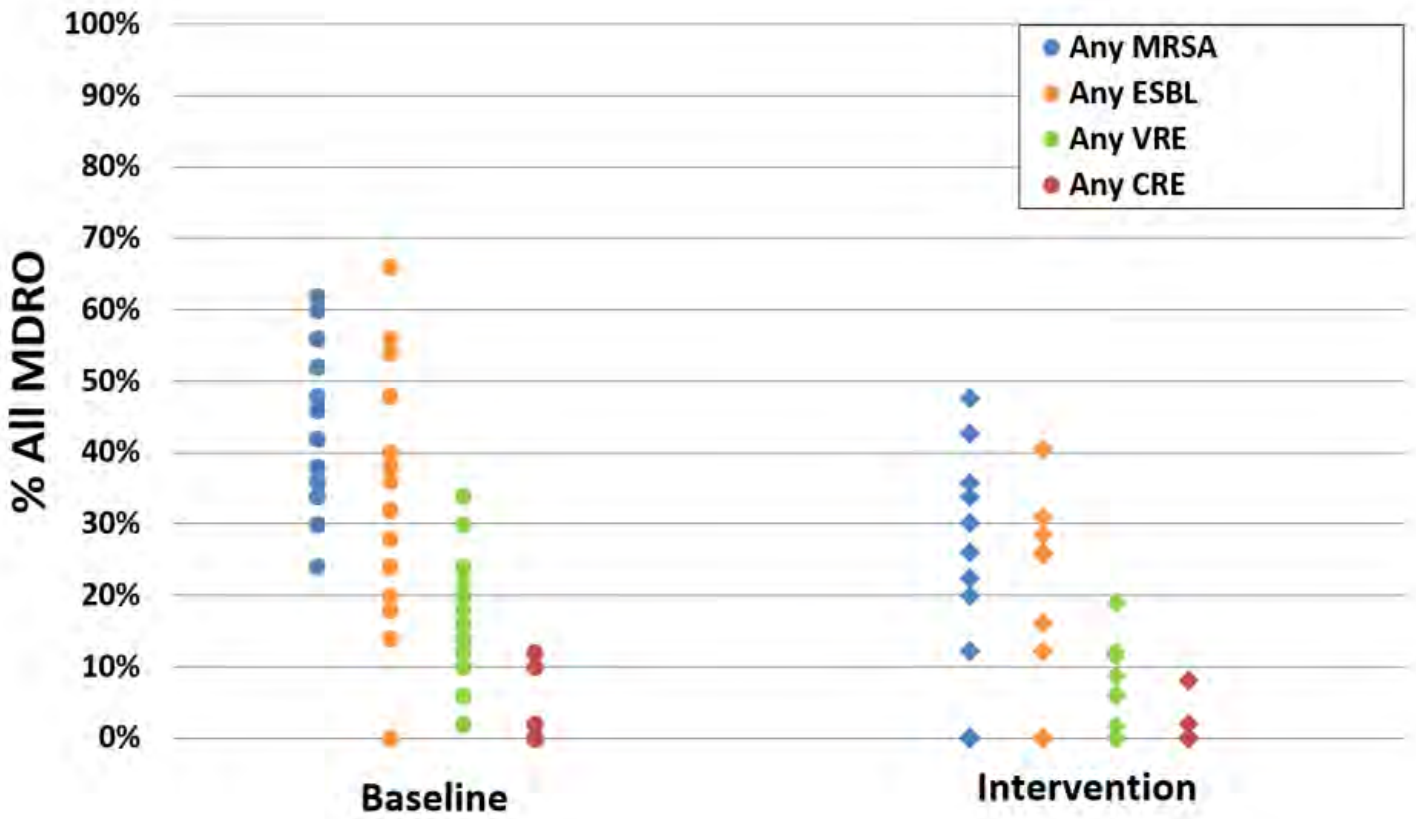
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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CalOptima A Public Agency Better. Together.

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team
(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

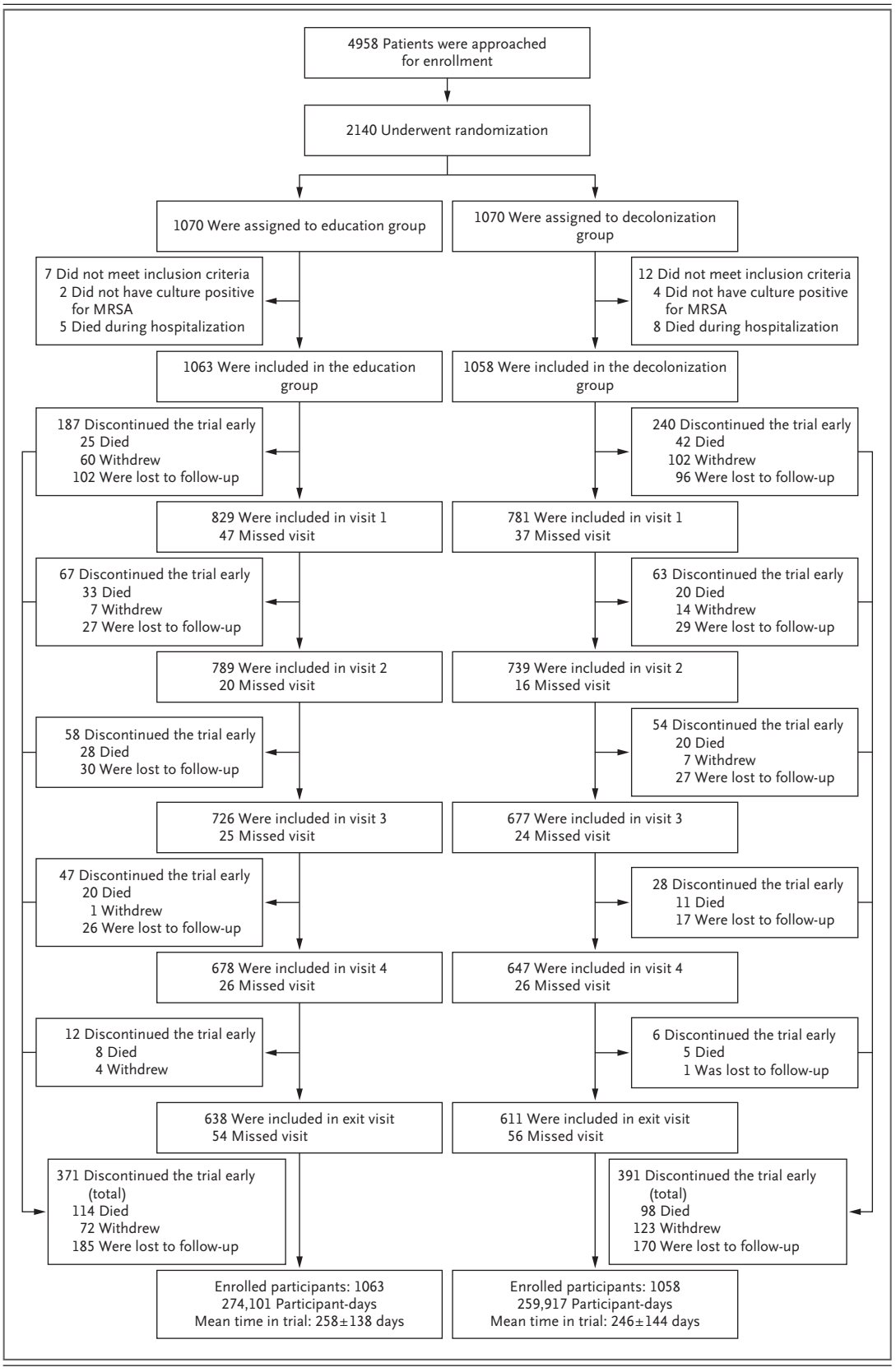

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

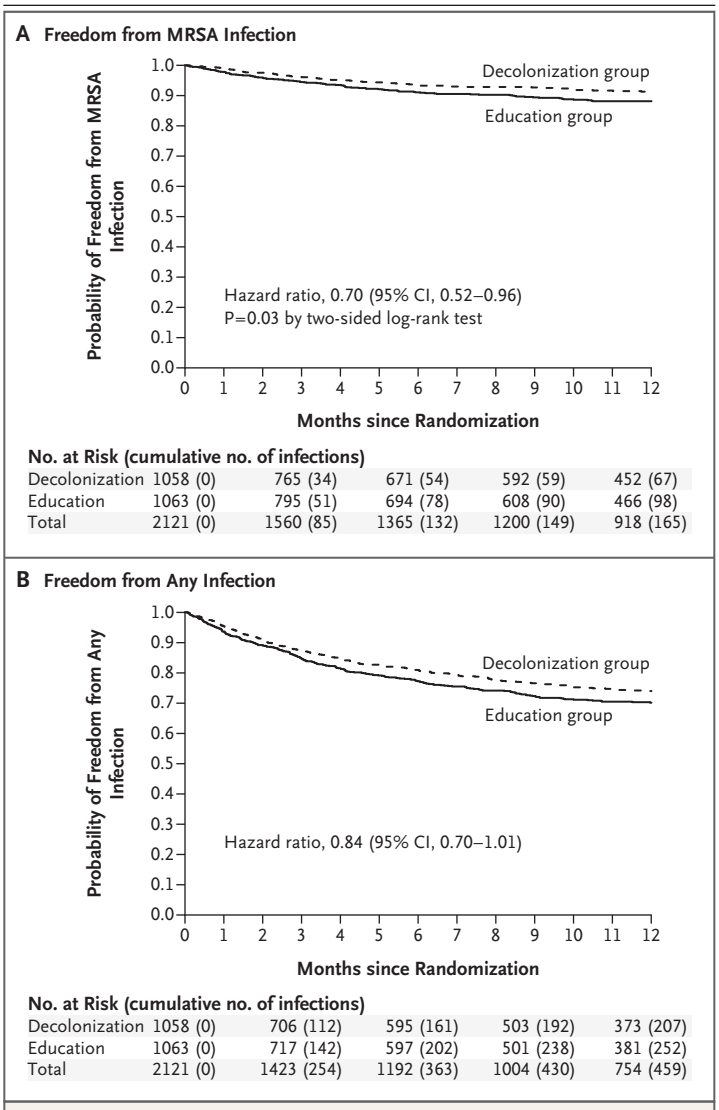

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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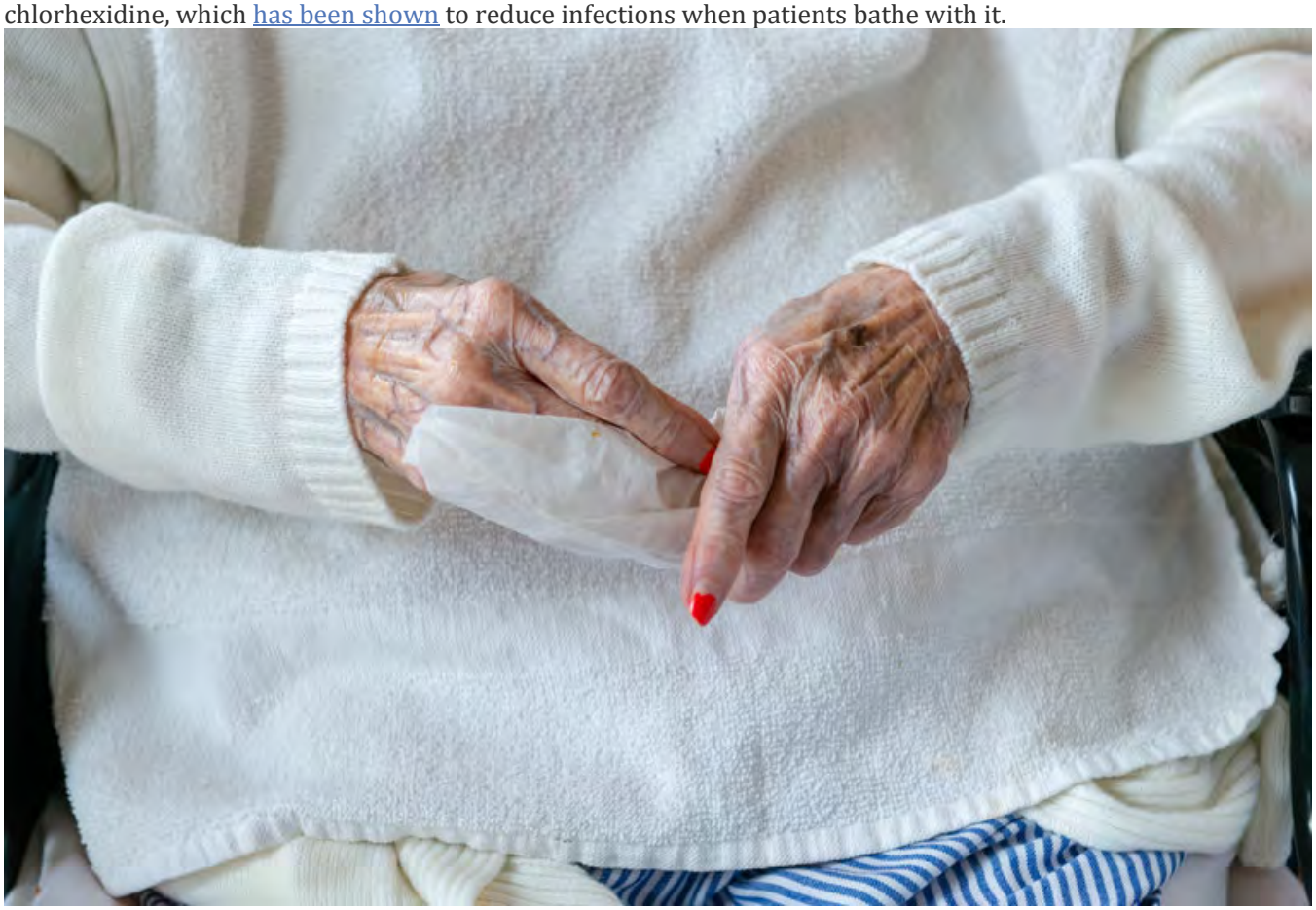
"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.



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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says**.** "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote handwashing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control work was new to many nursing homes, which don't have the same resources as hospitals, Lin said.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, said Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency. "We don't have an infinite amount of time," he said. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, said Huang, who is leading the project.

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County, and discovered they do so far more than imagined. That prompted a key question: "What can we do to not just protect our patients but to protect them when they start to move all over the place?" she recalled.

Her previous research showed that patients with the MRSA bacteria who used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic, could reduce their risk of developing a MRSA infection by 30%. But all the patients in that study, published in February in the New England Journal of Medicine, already had been discharged from hospitals.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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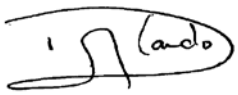
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

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5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

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

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

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B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorizing Modifications to the Post-Acute Infection Prevention Quality Initiative During the Coronavirus Disease (COVID-19) Crisis

Contact

David Ramirez, MD, Chief Medical Officer, 714-246-8400
Emily Fonda, M.D., MMM, CHCQM, Deputy Chief Medical Officer, 714-246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to temporarily modify the Post-Acute Infection Prevention Quality Initiative (PIPQI) by:

1. Suspending skin testing requirements during the Coronavirus Disease (COVID-19) pandemic, and
2. Allowing early disbursement of the first quarterly incentive payment (January – March 2020) and prepayment of the second quarterly payment (April – June 2020) due to added Personal Protective Equipment (PPE) and personnel costs in participating skilled nursing facilities.

Background/Discussion

The PIPQI program for contracted skilled nursing facilities (SNFs) was approved by the Board in June of 2019 as a means of infection prevention by replacing liquid soap with Chlorhexidine (CHG) soap for bathing and using Iodophor nasal swabs every other week. This protocol had been successful in demonstrating a significant reduction in Multi Drug Resistant Organisms (MDROs) on the skin of patients in 16 CalOptima contracted SNFs in a two-year study conducted by UCI Infectious Disease Professor, Dr. Susan Huang, from 2017–2019. Over the same time period, CalOptima data showed a 61% reduction in inpatient hospital costs for infection in patients from the same 16 SNFs. The combination of achievements has gained strong endorsement from the Centers for Disease Control and Prevention (CDC).

Over the past six months, the CDC has been funding CalOptima's PIPQI trainer from University of California, Irvine, since the CDC has been fully engaged and supportive of the PIPQI program at CalOptima. Dr. John Jernigan, the Director of the Office of Healthcare-Associated Infections Prevention Research and Evaluation of the CDC's Division of Healthcare Quality Promotion, and his team have been following CalOptima's progress since the PIPQI program recently put the Plan on the national radar as the only county in the U.S. attempting such infection prevention.

Compliance from the current 24 participating contracted SNFs has been managed by tracking product invoices for Chlorhexidine (CHG) and Iodophor along with Hospital Acquired Infection (HAI) rates, which is ongoing. Added funding was recently requested in order to expand the program to include more SNFs and to retain two of CalOptima's Long Term Services and Supports (LTSS) nurses as full-time compliance officers, promoters, and trainers. Furthermore, the funding is currently available to provide quarterly financial incentives to the participating facilities with proven program adherence. The initial plan was to add random CHG skin testing in order to qualify for a $7,500 quarterly incentive for each facility. At its April 2, 2020, meeting, the Board approved allocation of Intergovernmental Transfer

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(IGT) 9 funds for certain initiatives. Included in this approval was $3.4 million in additional funding over a three (3) year period for the expansion of the PIPQI.

However, due to the current COVID-19 precautions and social distancing requirements, CalOptima's LTSS nurses are currently performing their functions remotely since entrance to SNFs has been curtailed in the interest of patient safety. CalOptima's LTSS nurses are also not currently allowed access to the facilities to collect CHG skin testing samples; nevertheless, our belief is that participating contracted SNF partners are continuing to perform infection control and have been successful in preventing a large outbreak of COVID-19, with the extra burden of PPE costs and personnel overtime. Under these extraordinary circumstances it is important to note that CHG's anti-viral, anti-bacterial, and anti-fungal properties have been emphasized to all the facility medical directors.

In view of the temporary constraints that preclude skin testing in order to qualify for financial incentives, a suspension of the skin testing requirement is proposed for the duration of the national emergency, along with release of the quarterly incentive funds to our participating SNF partners, who are safeguarding the health and safety of a vulnerable population. The CHG skin testing protocol will be re-implemented when safety permits and the national emergency has come to an end.

Fiscal Impact

The recommended action to temporarily modify the PIPQI by suspending skin testing requirements during the Coronavirus Disease pandemic and early disbursement of quarterly payments to qualifying SNFs has no additional fiscal impact to CalOptima's operating budget. Staff anticipates that IGT 9 revenue from the State will be sufficient to cover the expenditures for the PIPQI.

Rationale for Recommendation

The recommended actions will support CalOptima's efforts to continue providing quality healthcare to our members residing at SNFs during the COVID-19 public health crisis and allow CalOptima to continue its robust partnership with participating SNFs after the current pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 6, 2019, Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments
2. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
3. PIPQI Presentation

/s/ Richard Sanchez — *04/10/2020*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

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

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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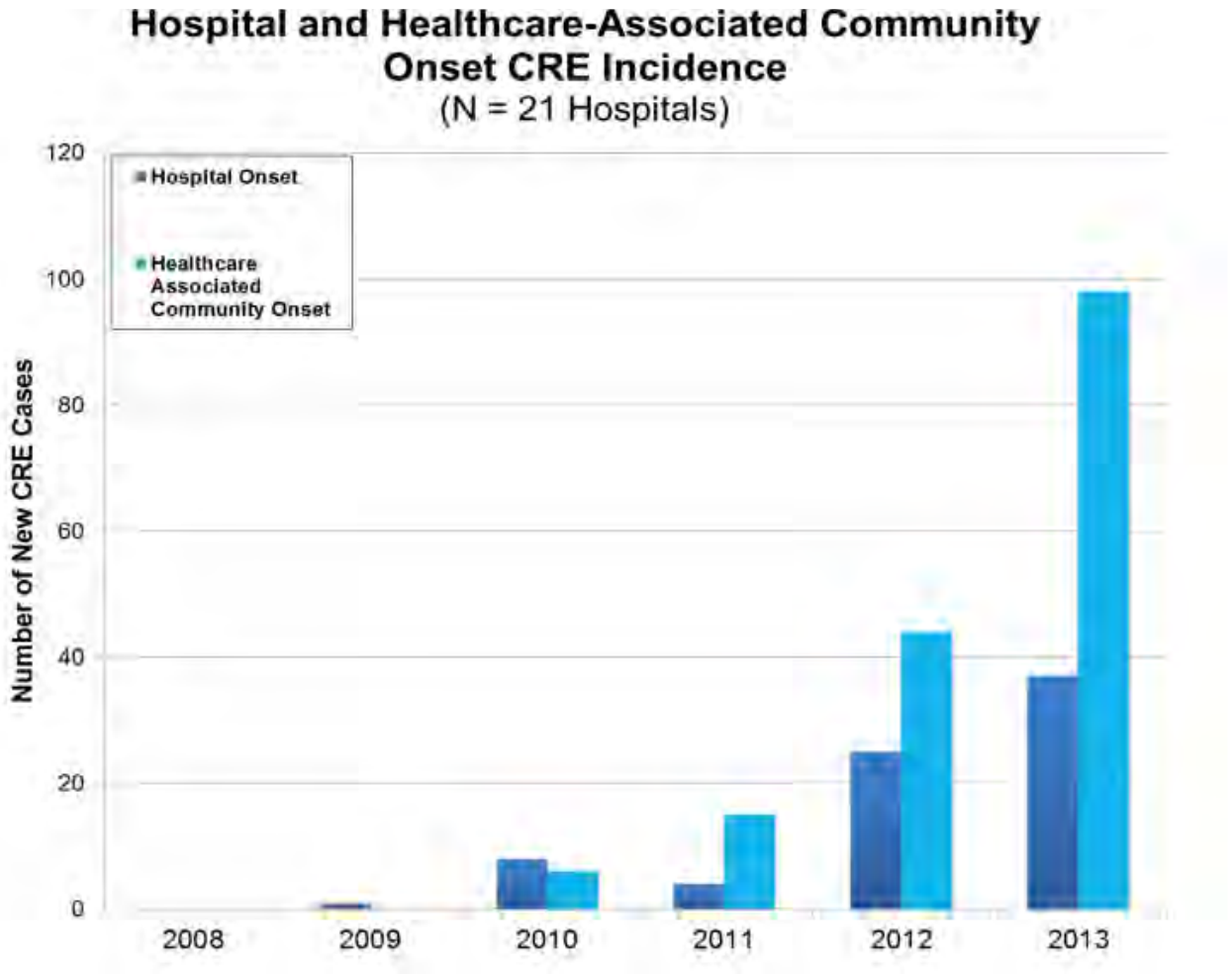
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

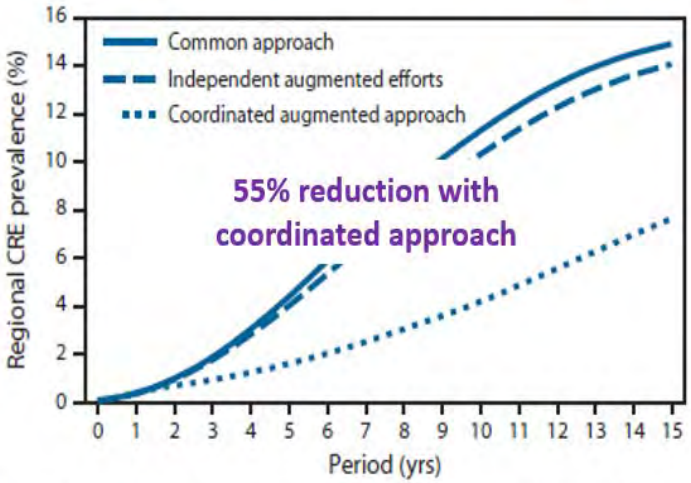
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[8]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*

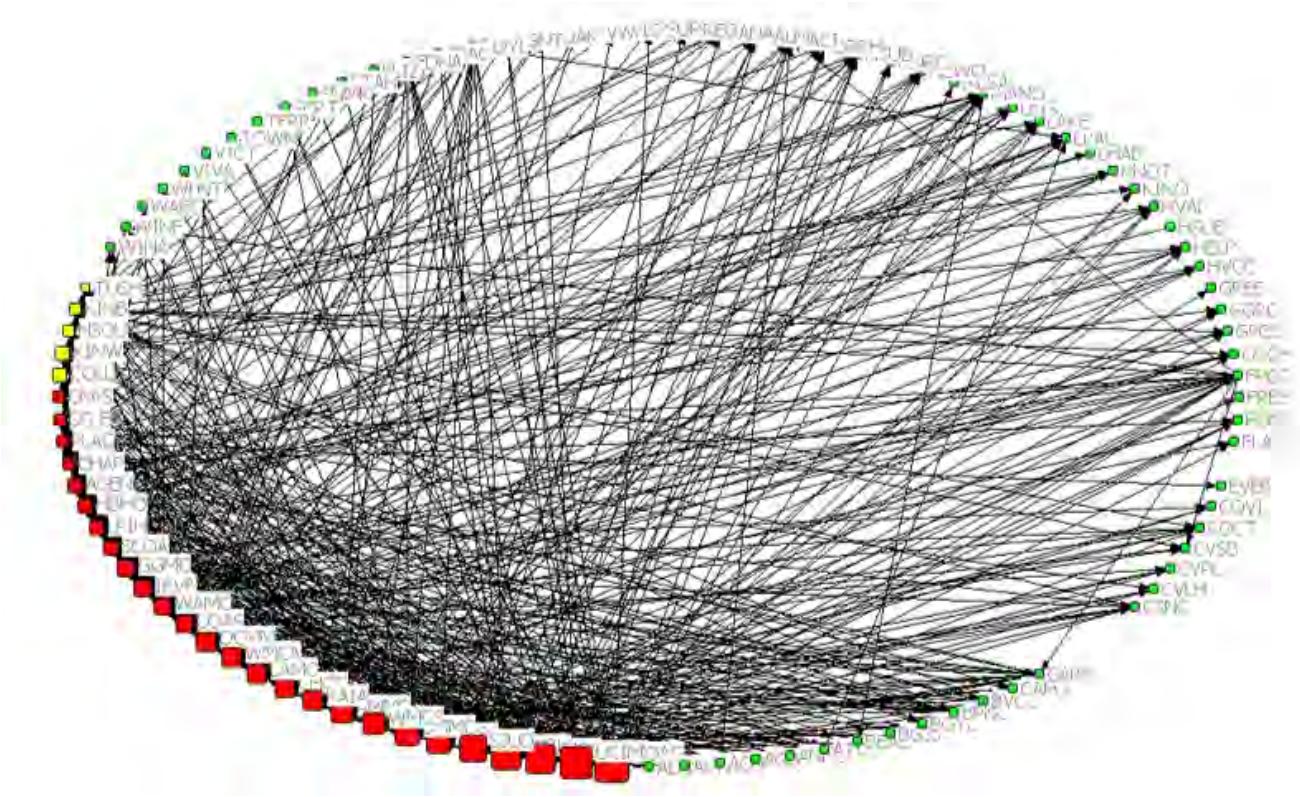


* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

Extent of the Problem

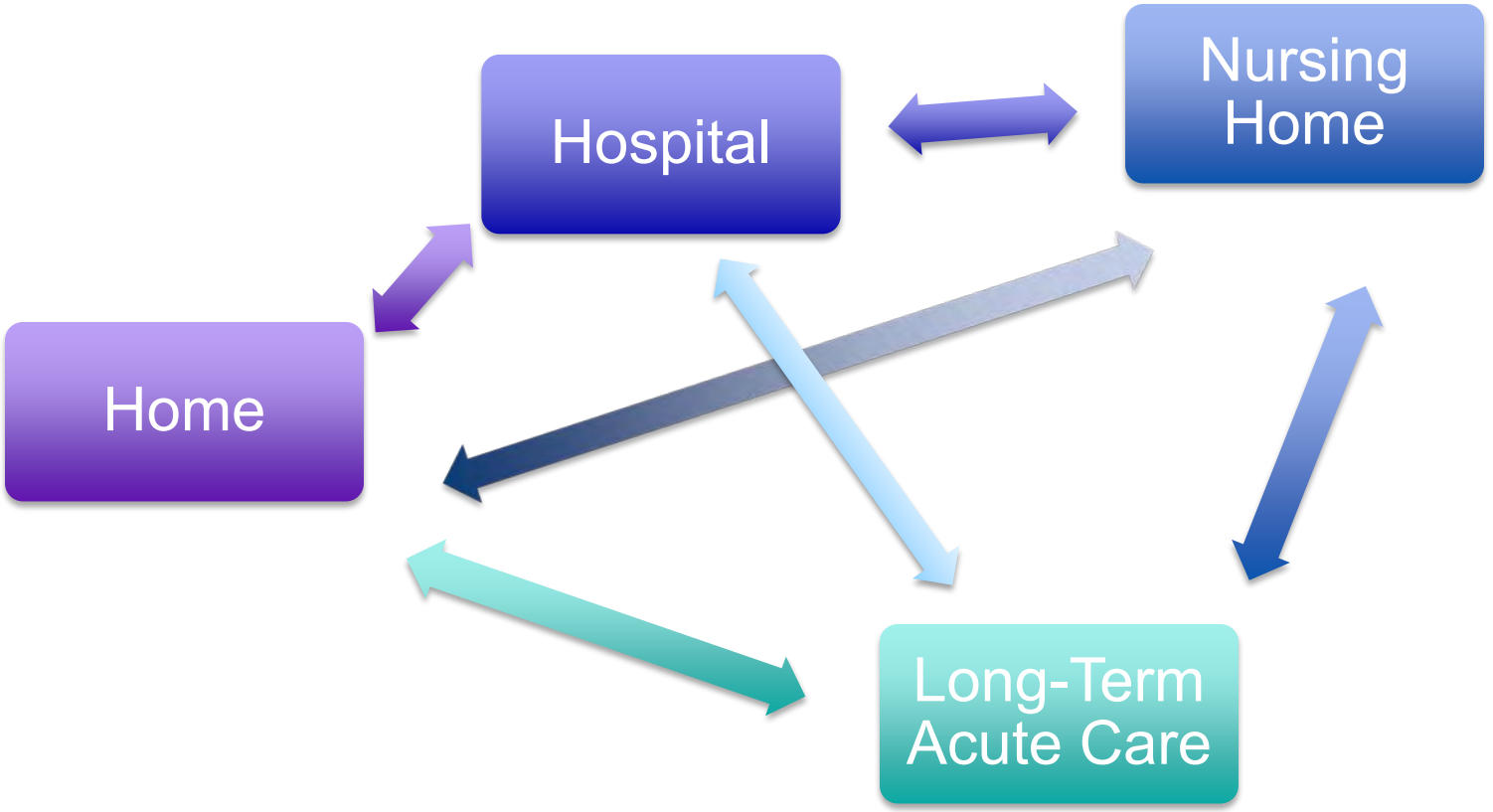
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

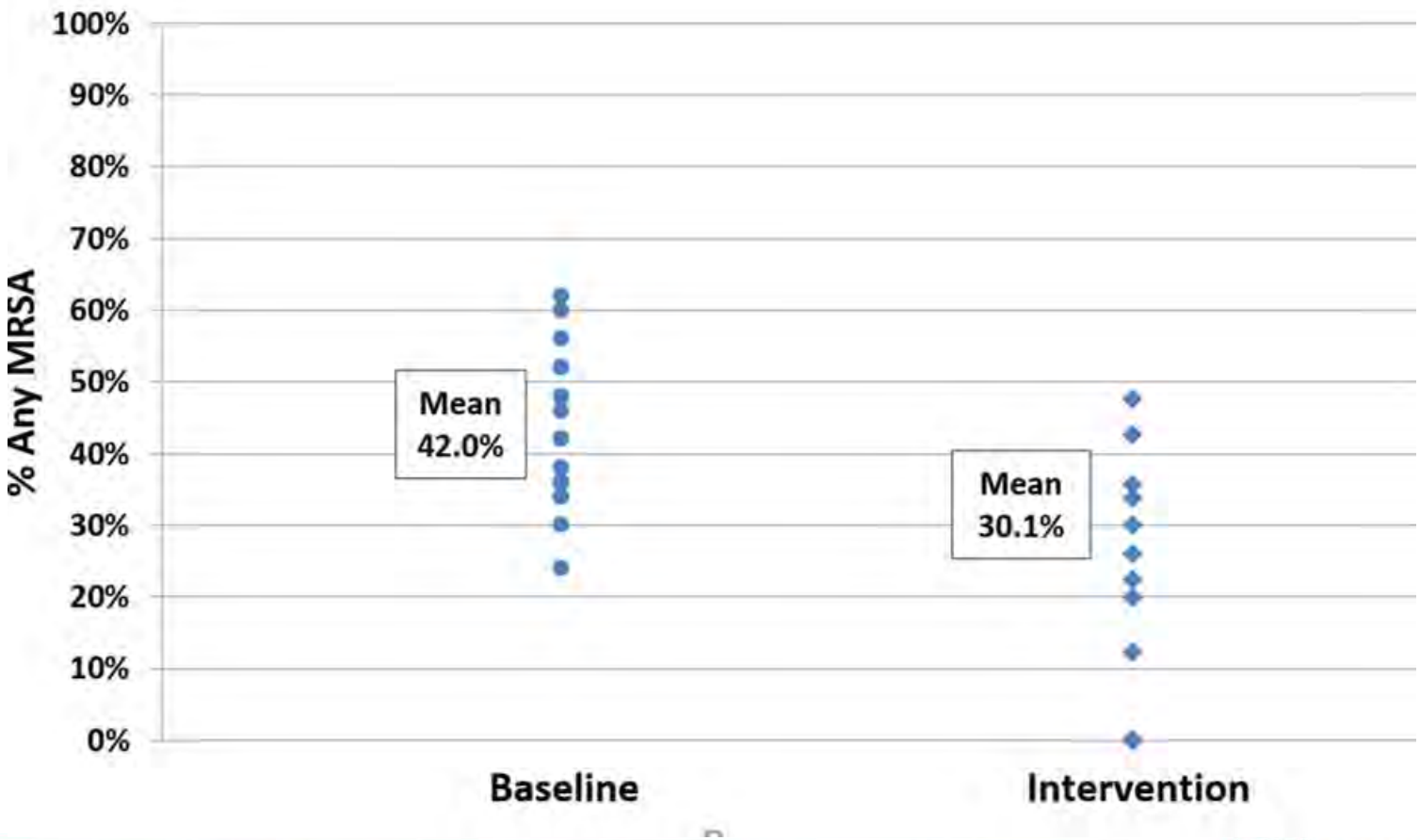
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



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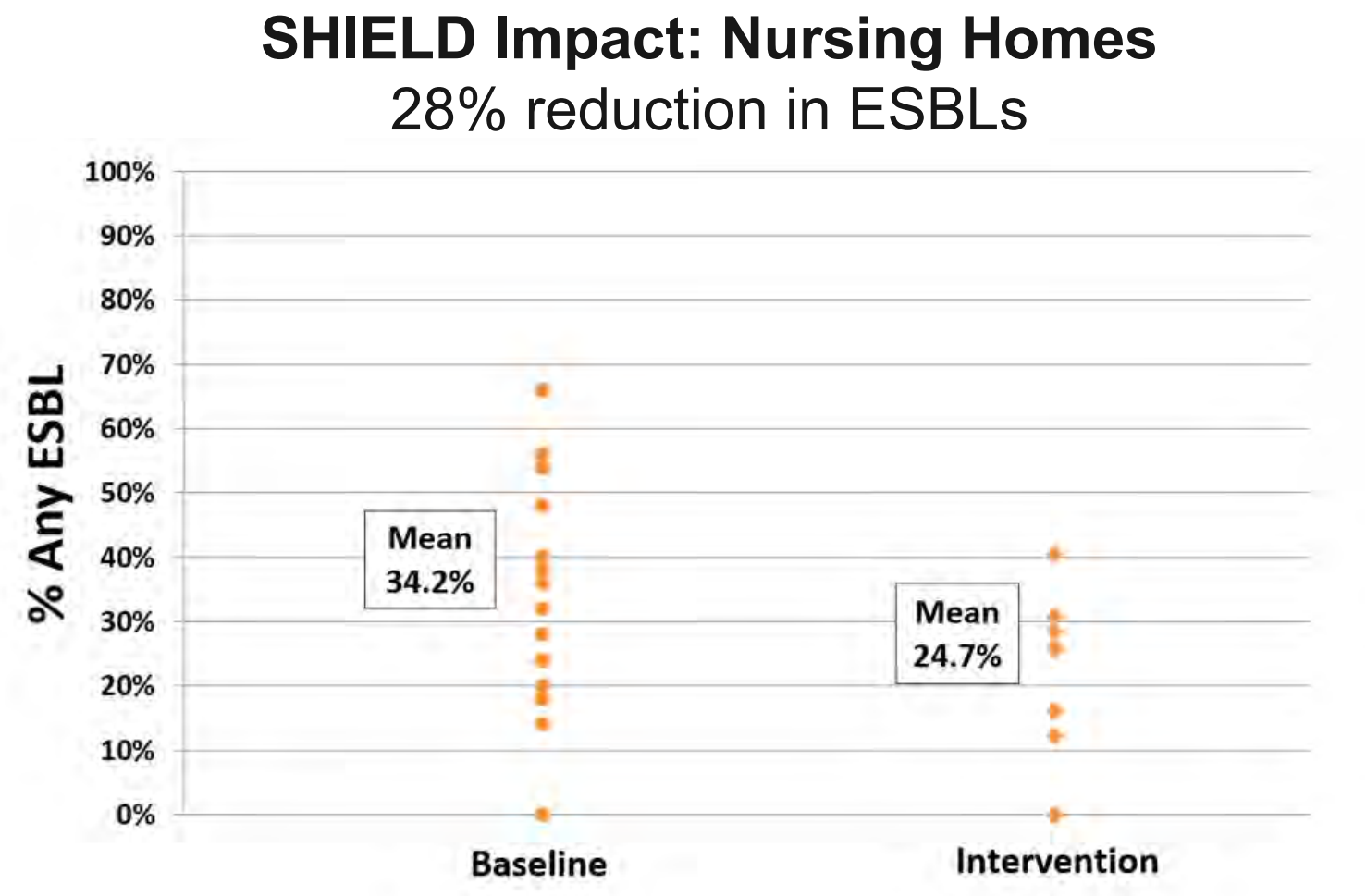
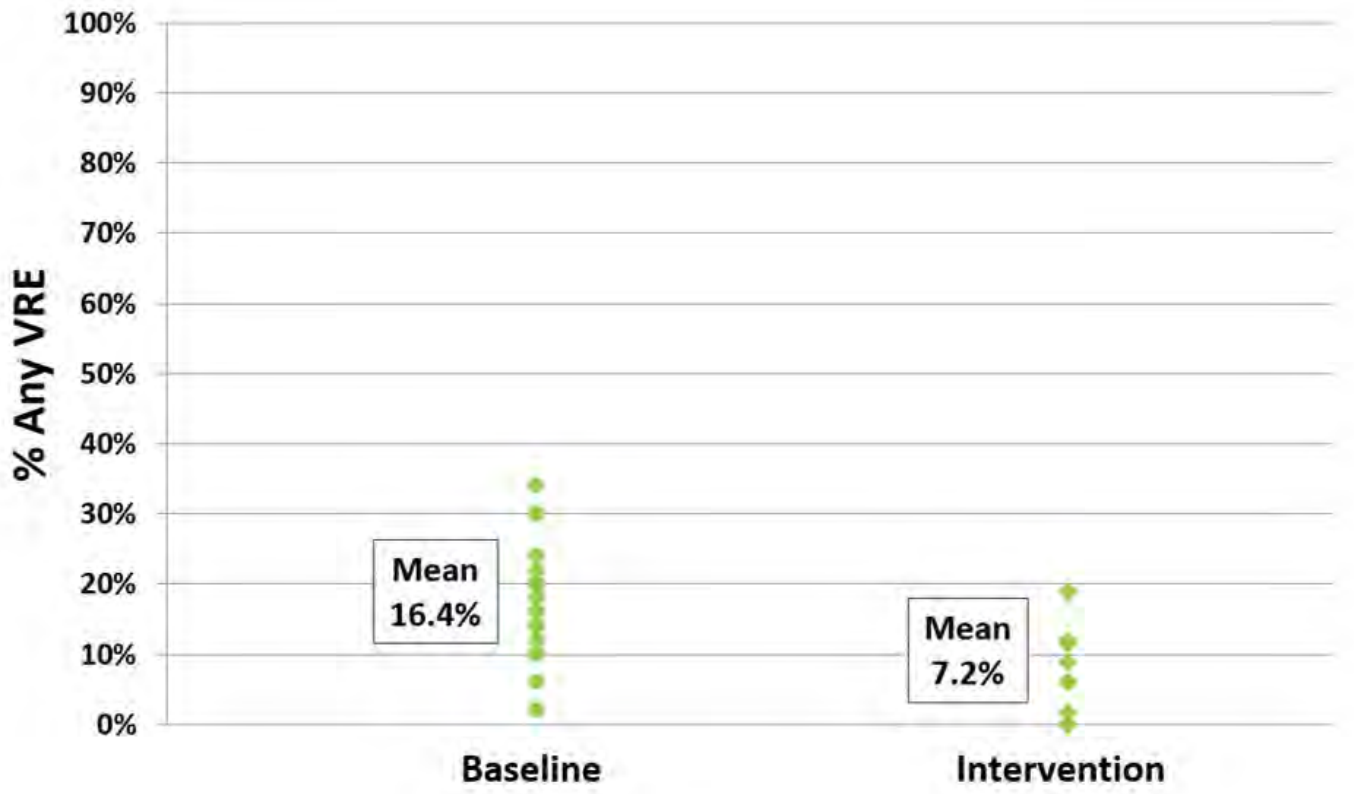
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

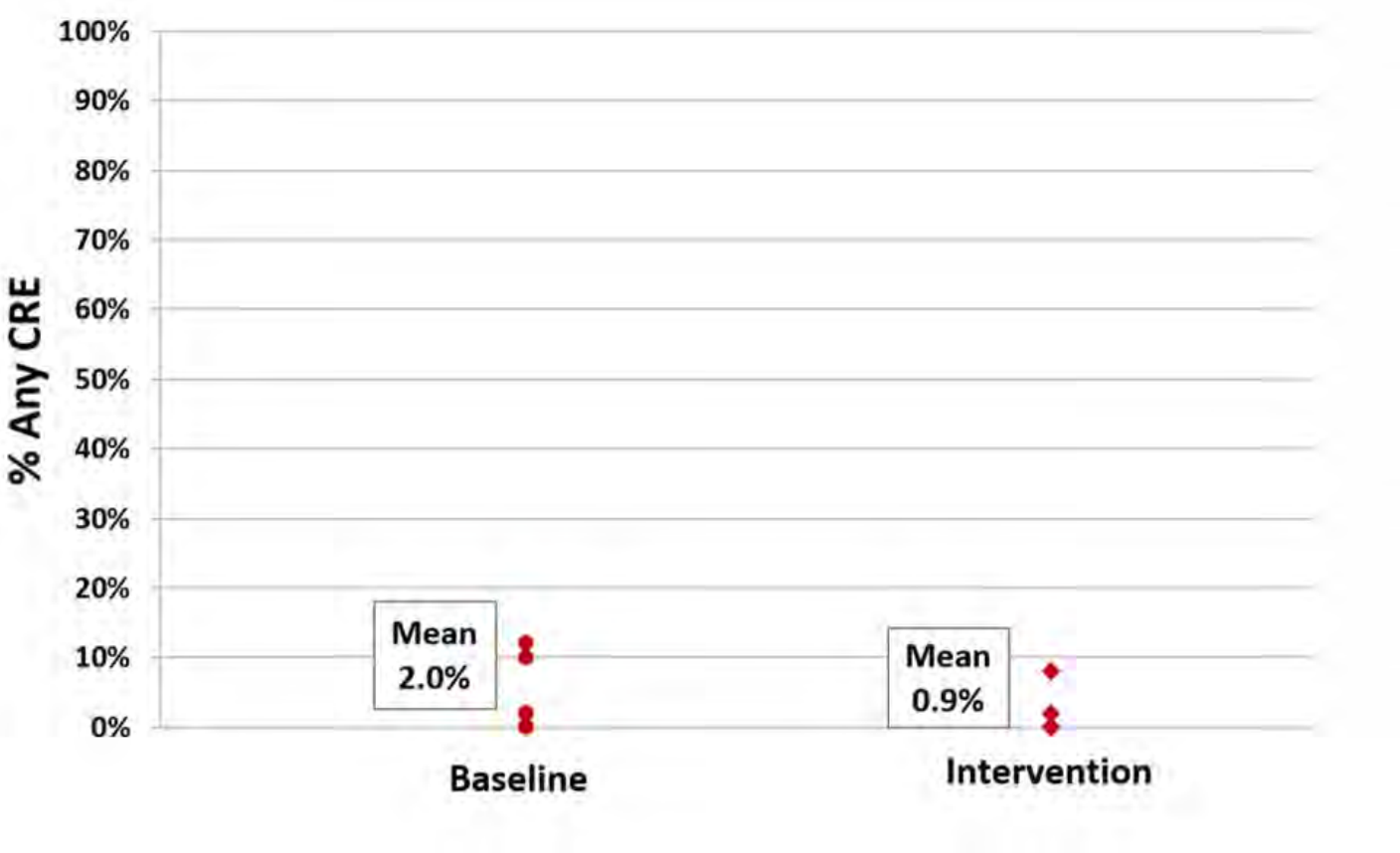
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

55% reduction in CRE



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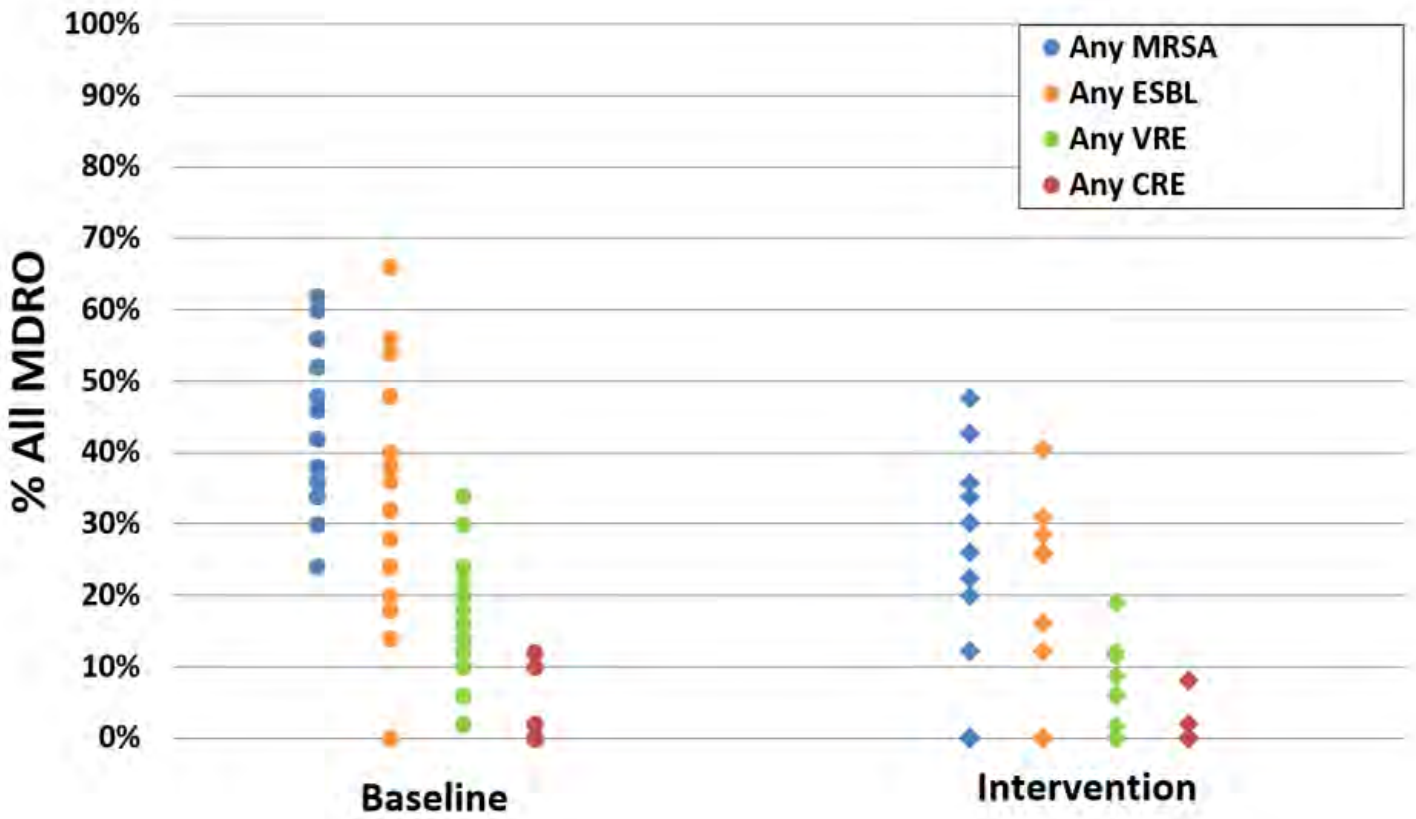
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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CalOptima A Public Agency Better. Together.

Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team
(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Huang at the University of California Irvine School of Medicine, Division of Infectious Diseases, 100 Theory, Suite 120, Irvine, CA 92617, or at sshuang@uci.edu.

N Engl J Med 2019;380:638-50.
DOI: 10.1056/NEJMoa1716771

Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

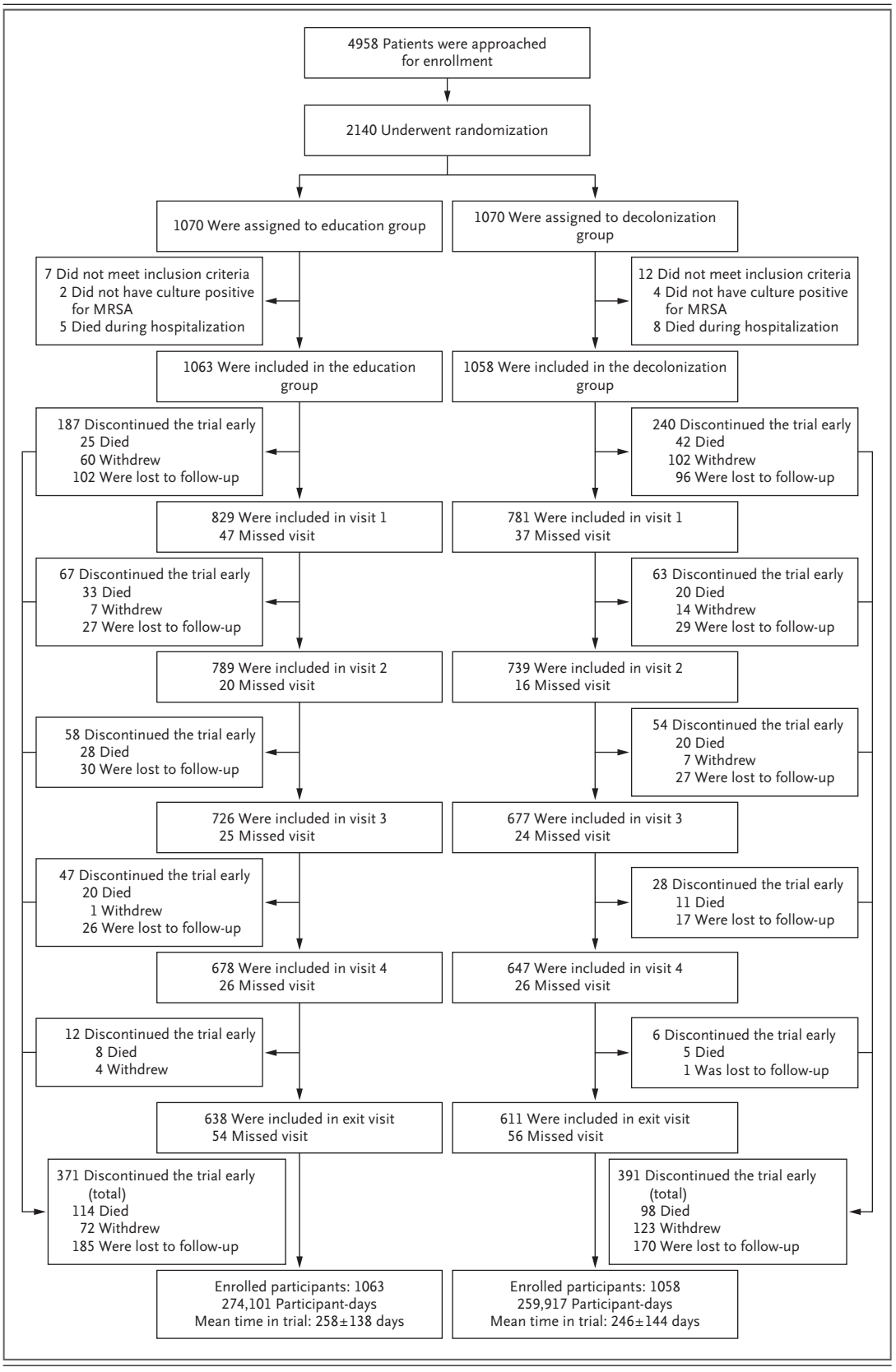

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

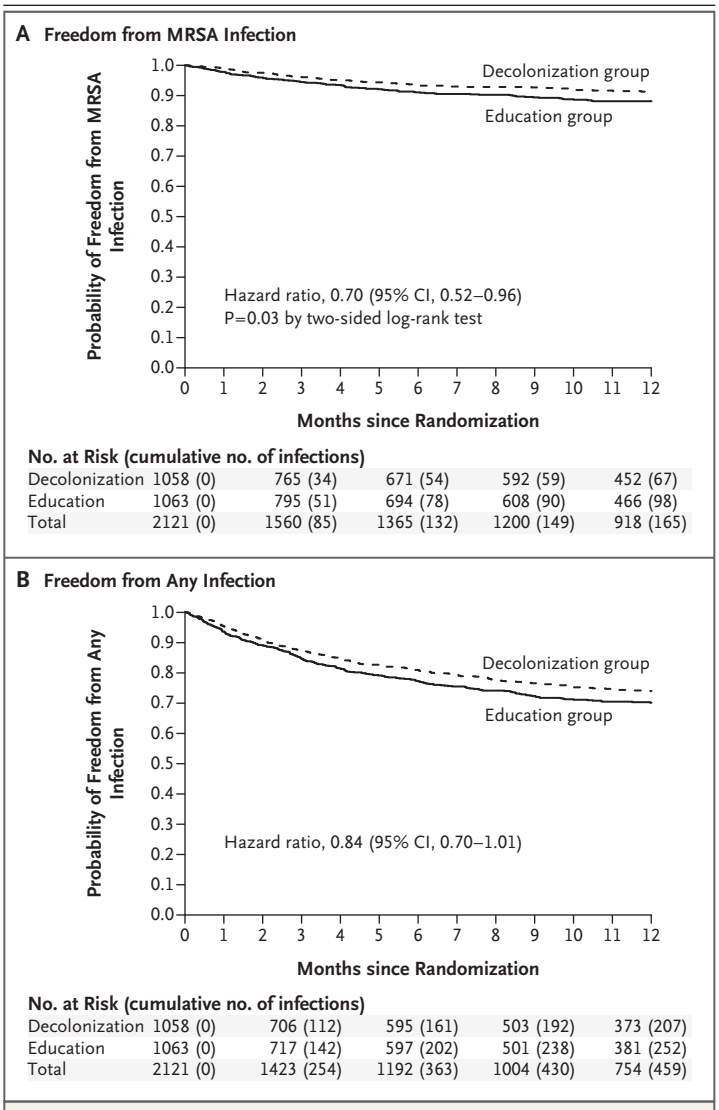

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

The authors' full names and academic degrees are as follows: Susan S. Huang, M.D., M.P.H, Raveena Singh, M.A., James A. McKinnell, M.D., Steven Park, M.D., Ph.D., Adrijana Gombosev, M.S., Samantha J. Eells, M.P.H., Daniel L. Gillen, Ph.D., Diane Kim, B.S., Syma Rashid, M.D., Raul Macias-Gil, M.D., Michael A. Bolaris, M.D., Thomas Tjoa, M.P.H., M.S., Chenghua Cao, M.P.H., Suzie S. Hong, M.S., Jennifer Lequieu, B.S., Eric Cui, B.S., Justin Chang, B.S., Jiayi He, M.S., Kaye Evans, B.A., Ellena Peterson, Ph.D., Gail Simpson, M.D., Philip Robinson, M.D., Chester Choi, M.D., Charles C. Bailey, Jr., M.D., James D. Leo, M.D., Alpesh Amin, M.D., Donald Goldmann, M.D., John A. Jernigan, M.D., Richard Platt, M.D., Edward Septimus, M.D., Robert A. Weinstein, M.D., Mary K. Hayden, M.D., and Loren G. Miller, M.D., M.P.H.

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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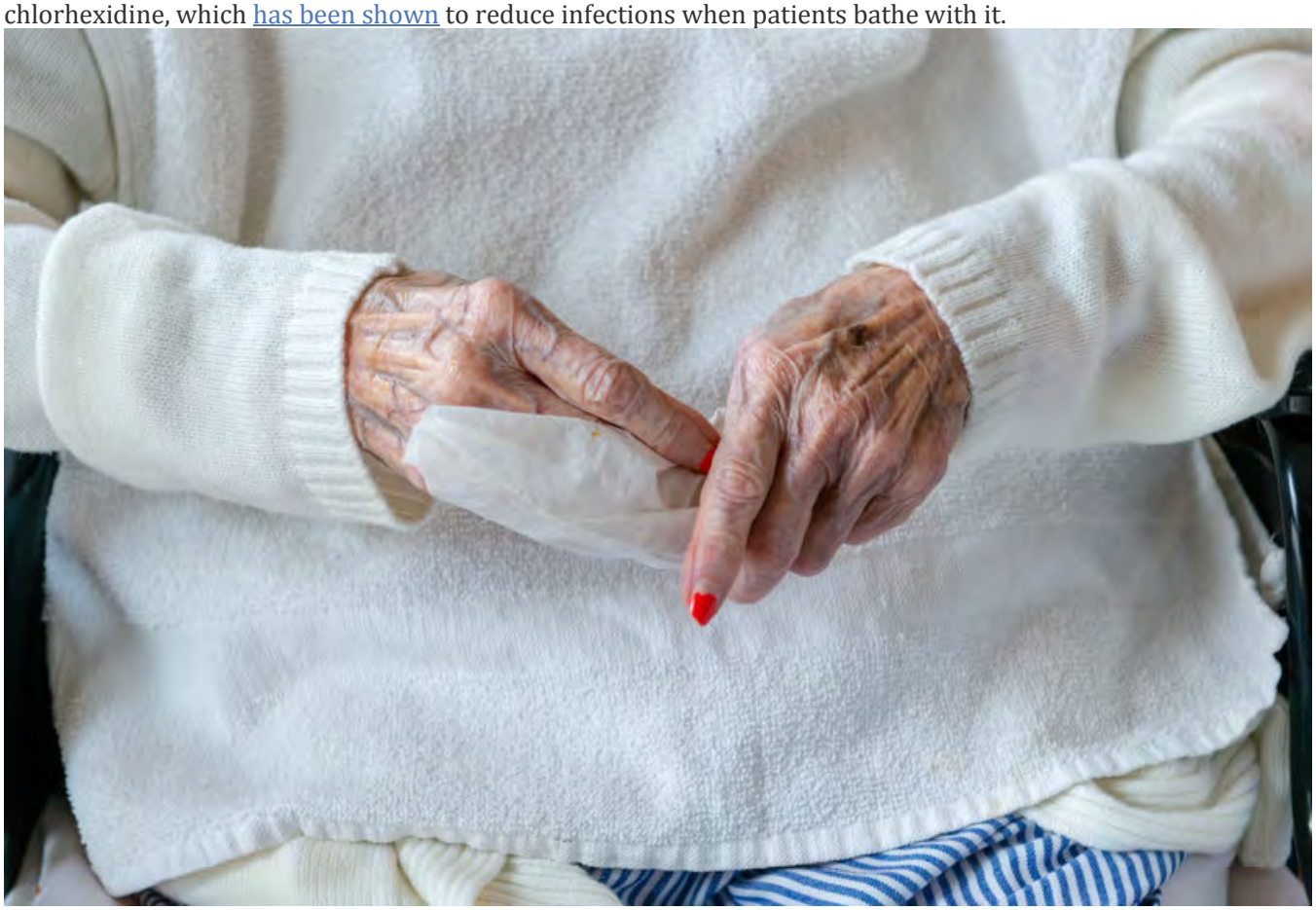
"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.



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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says**.** "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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long-term acute care hospitals perform the cleaning — also called “decolonizing” — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

“It kills germs,” Shinkle responded.

“That’s right — it protects you from infection.”

In a nearby room, senior project coordinator Raveena Singh from UC-Irvine talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. “If you have some kind of open wound or cut, it helps protect you from getting an infection,” Singh said. “And we are not just protecting you, one person. We protect everybody in the nursing home.”

Coca said she had a cousin who had spent months in the hospital after getting MRSA. “Luckily, I’ve never had it,” she said.

Coventry Court administrator Shaun Dahl said he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. “They were sick there and they are sick here,” Dahl said.

Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang said. After 18 months, researchers saw a 25% decline in drug-resistant organisms in nursing home residents, 34% in patients of long-term acute care hospitals and 9% in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also shows a promising ripple effect in facilities that aren’t part of the effort, a sign that the project may be starting to make a difference in the county, said Zahn of the Orange County Health Care Agency.

“In our community, we have seen an increase in antimicrobial-resistant infections,” he said. “This offers an opportunity to intervene and bend the curve in the right direction.”

Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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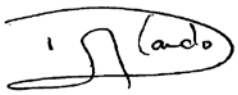
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Office, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
    a. Additional initiative(s) related to member access and engagement; and
    b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

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Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees' recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program's financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting $40.5 million of the anticipated $45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million

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4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee
Board of Directors' Quality Assurance Committee

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

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CalOptima
A Public Agency
Better. Together.

Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting
April 2, 2020

David Ramirez, M.D., Chief Medical Officer
Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

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IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

Proposed Allocation and Initiatives

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. W hole Child Model Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

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services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact

The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation

Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence

Gary Crockett, Chief Counsel

Attachment

Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

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

8/29/2018 — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

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2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

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uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

Inpatient				
Outpatient				
All Other				
Total	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

   If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

   (i) The name of the entity transferring funds:

   (ii) The operational nature of the entity (state, county, city, other):

   (iii) The source of the funds:
   (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

   (iv) Does the transferring entity have general taxing authority? *(Yes / No)*

   (v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.
[2]Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact
The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation
The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

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

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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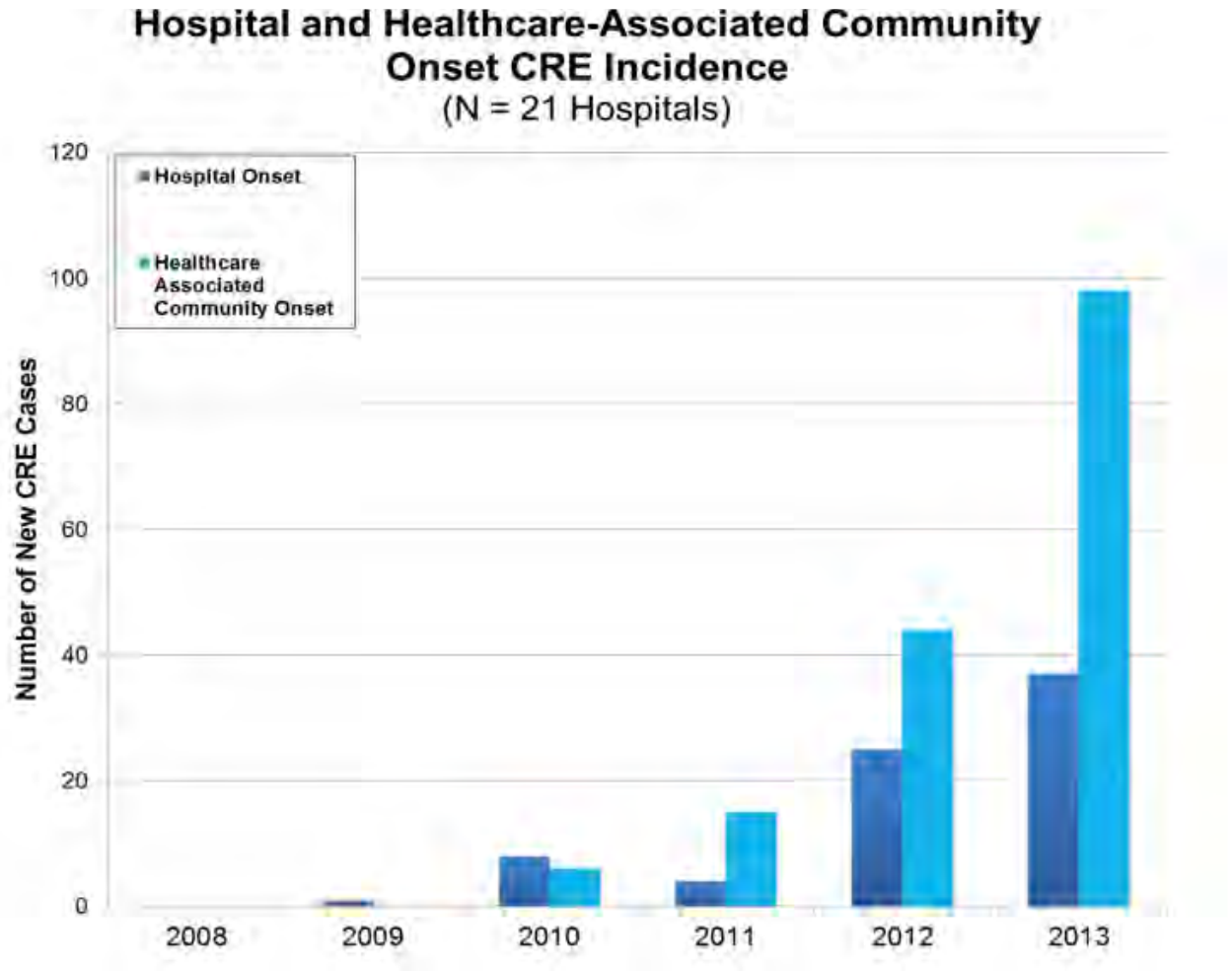
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

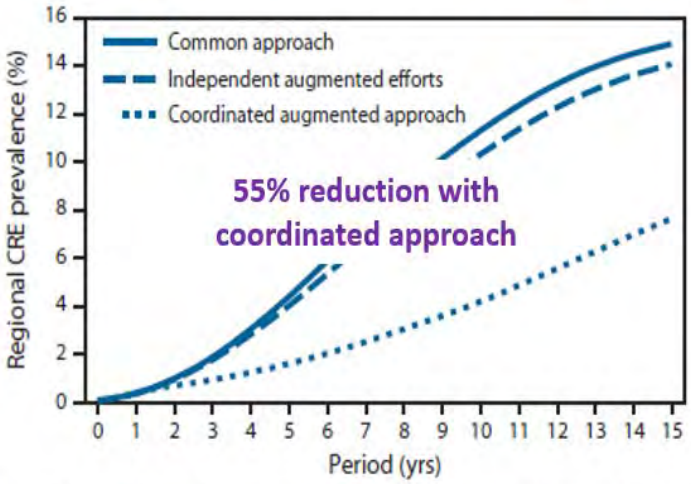
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[8]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*



* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

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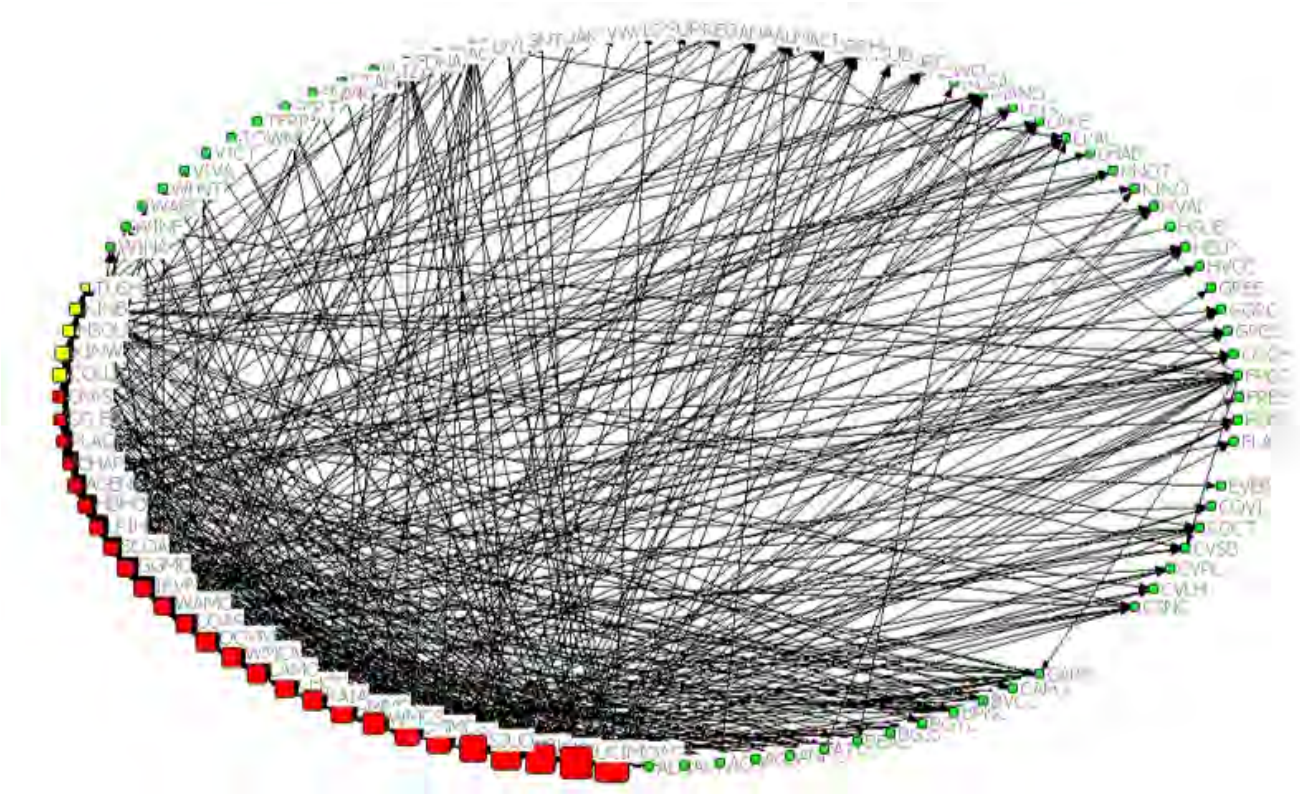
Extent of the Problem

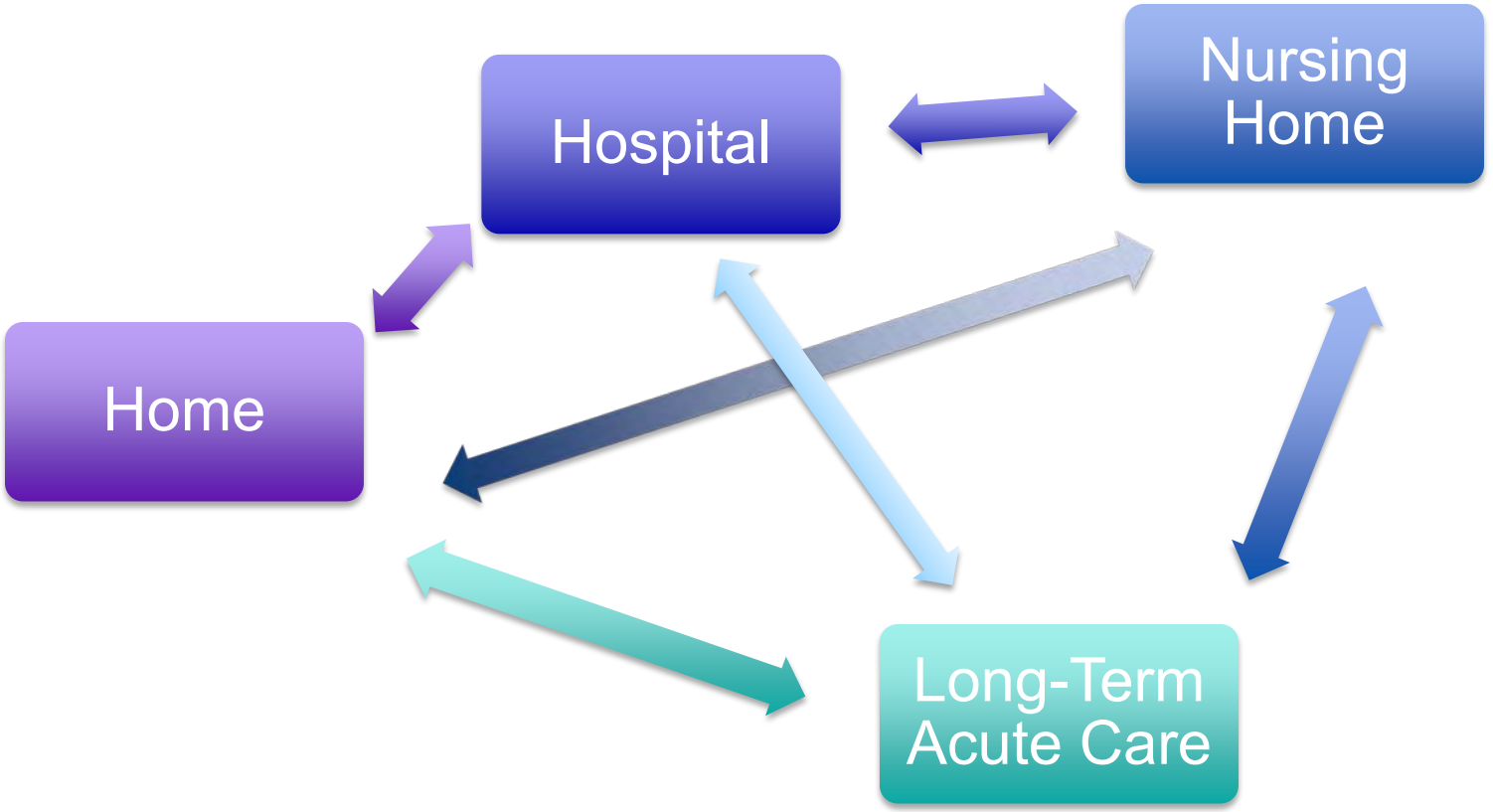
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

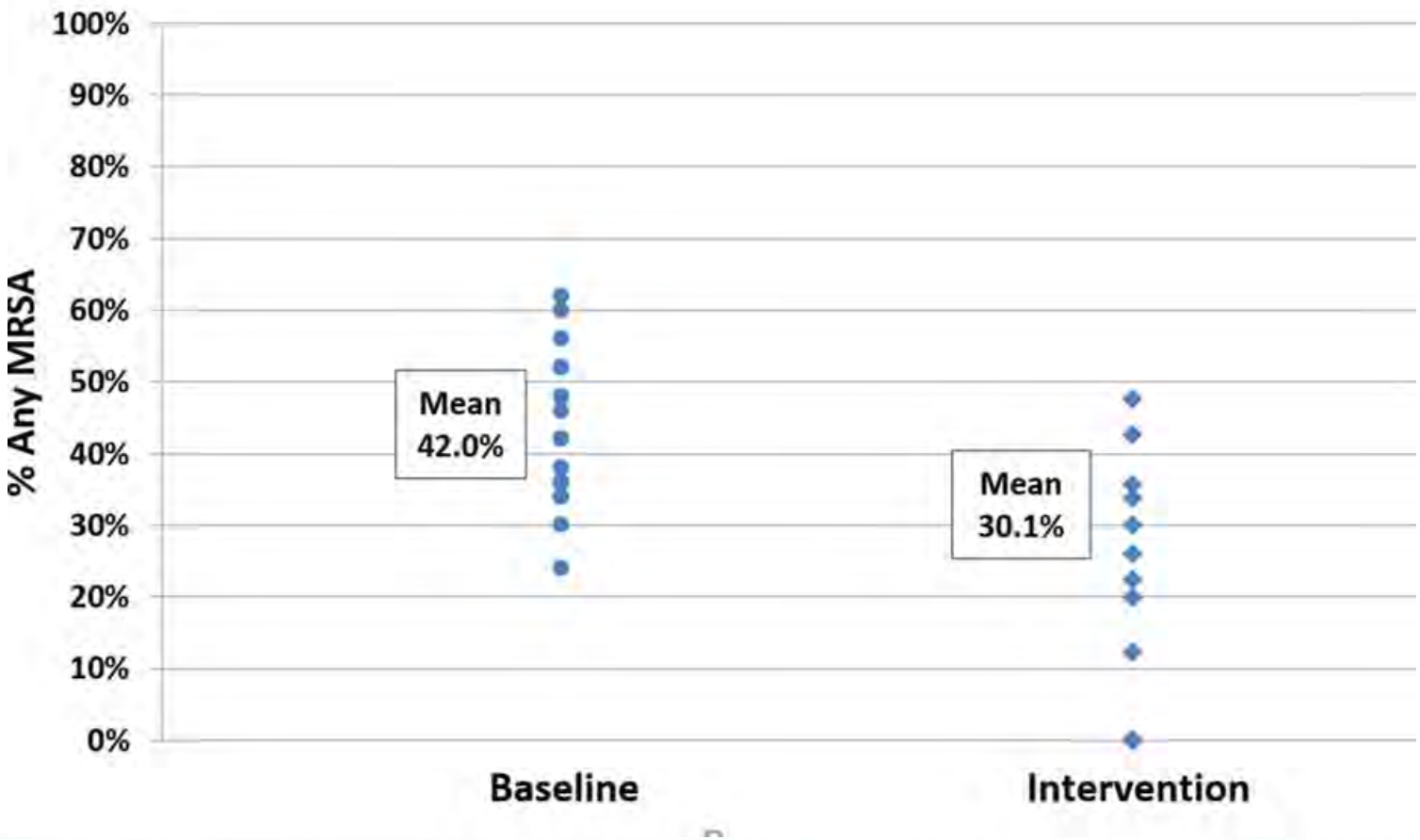
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



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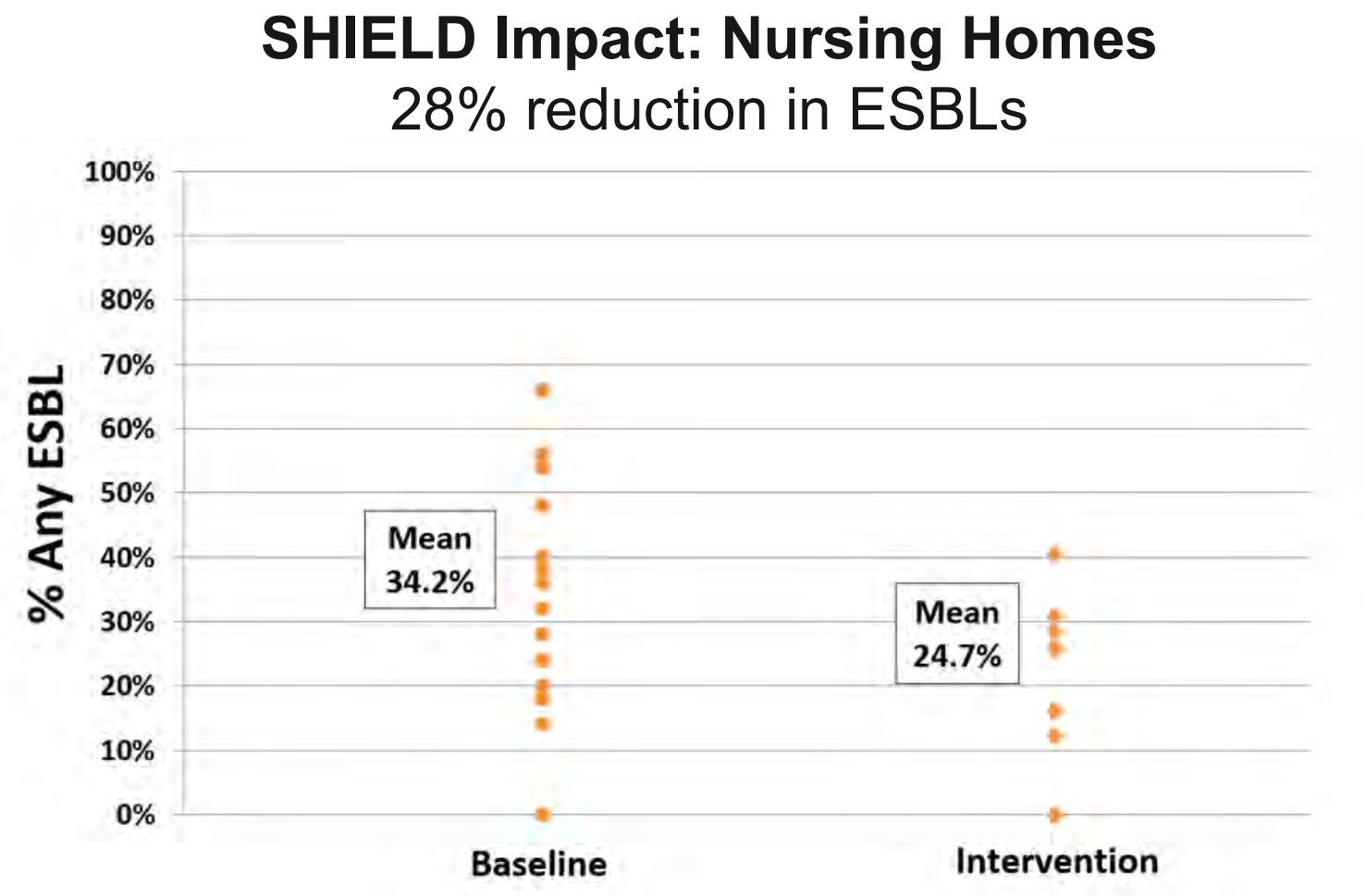
SHIELD Outcomes (cont)



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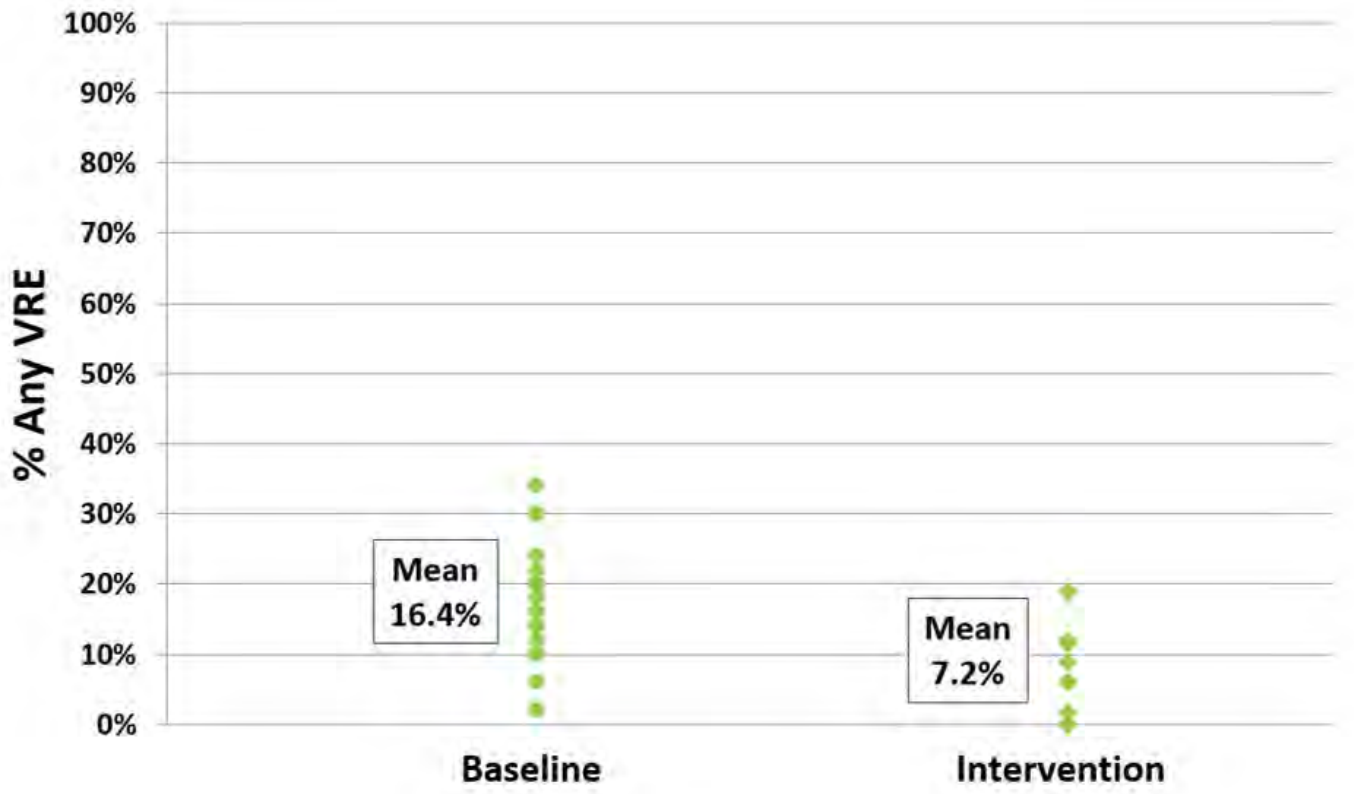
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

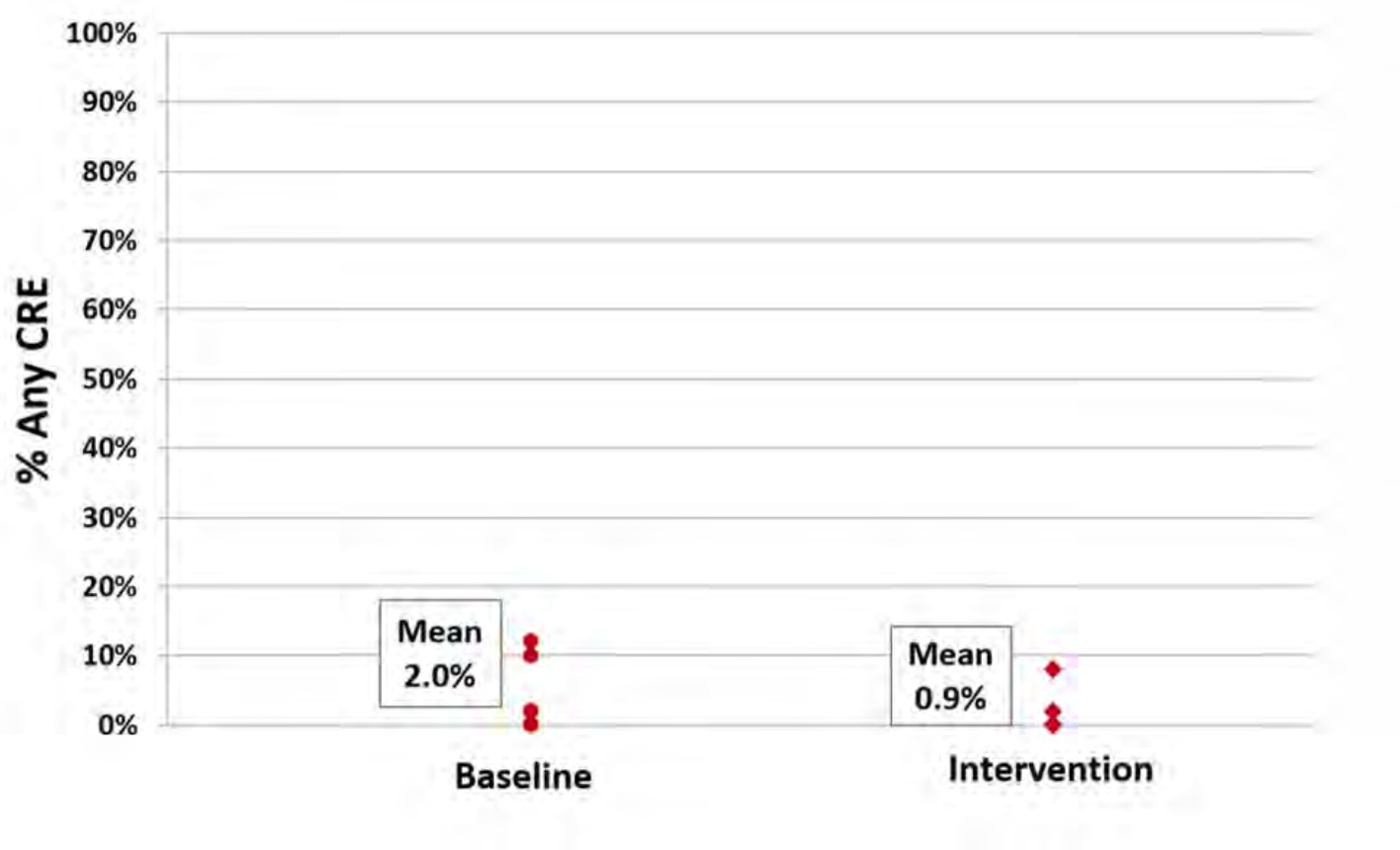
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

55% reduction in CRE



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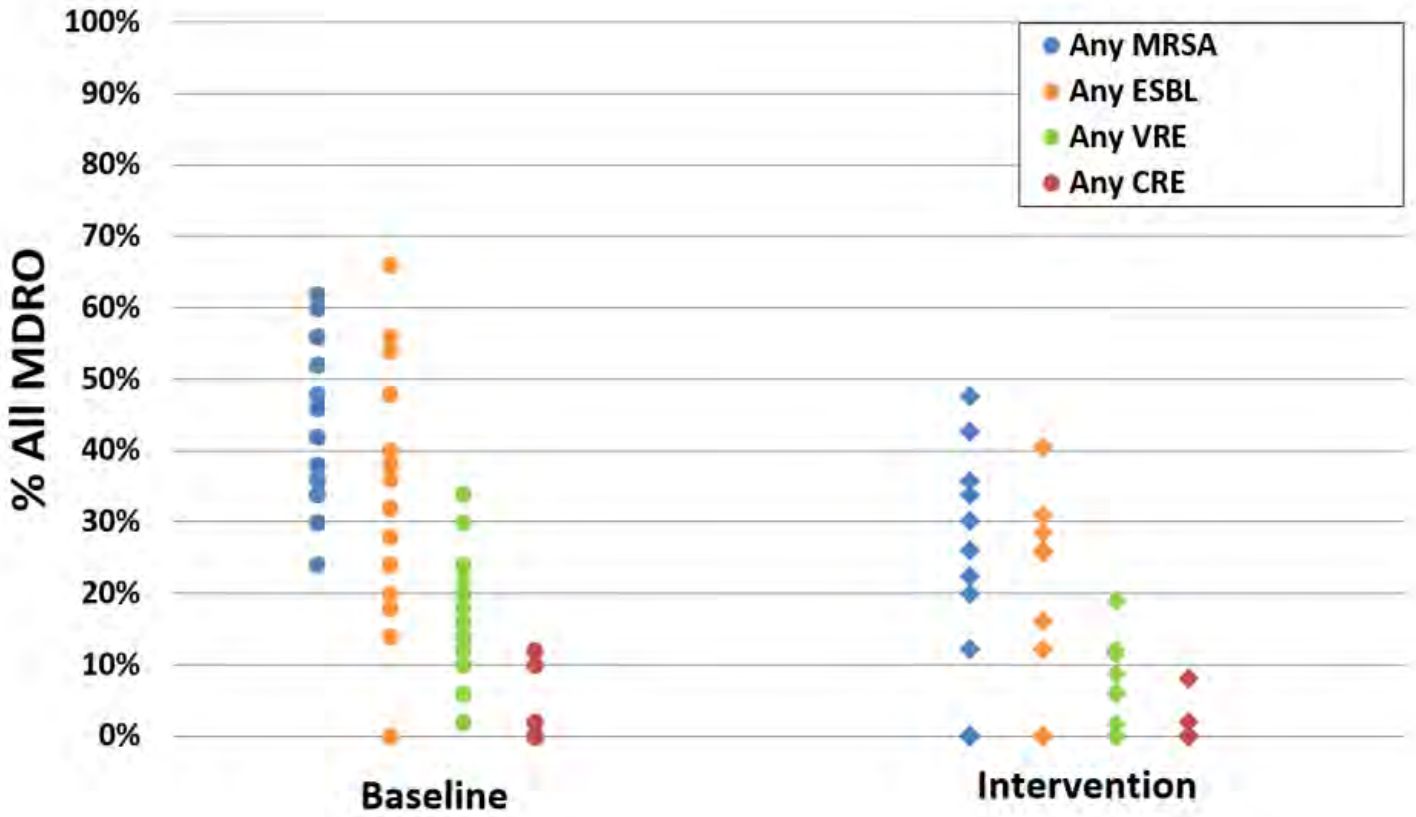
SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team
(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

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ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

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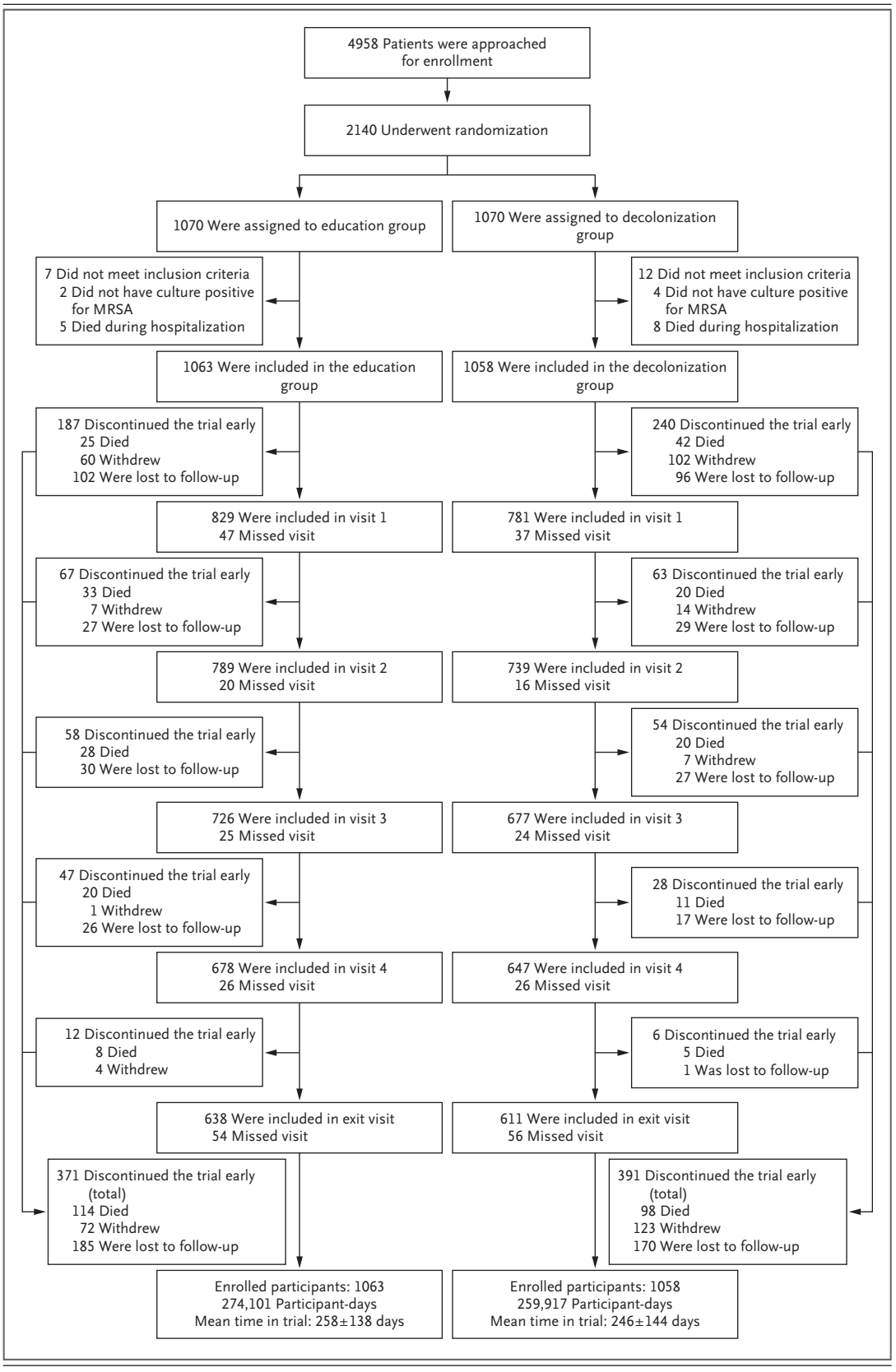

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

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Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

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categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

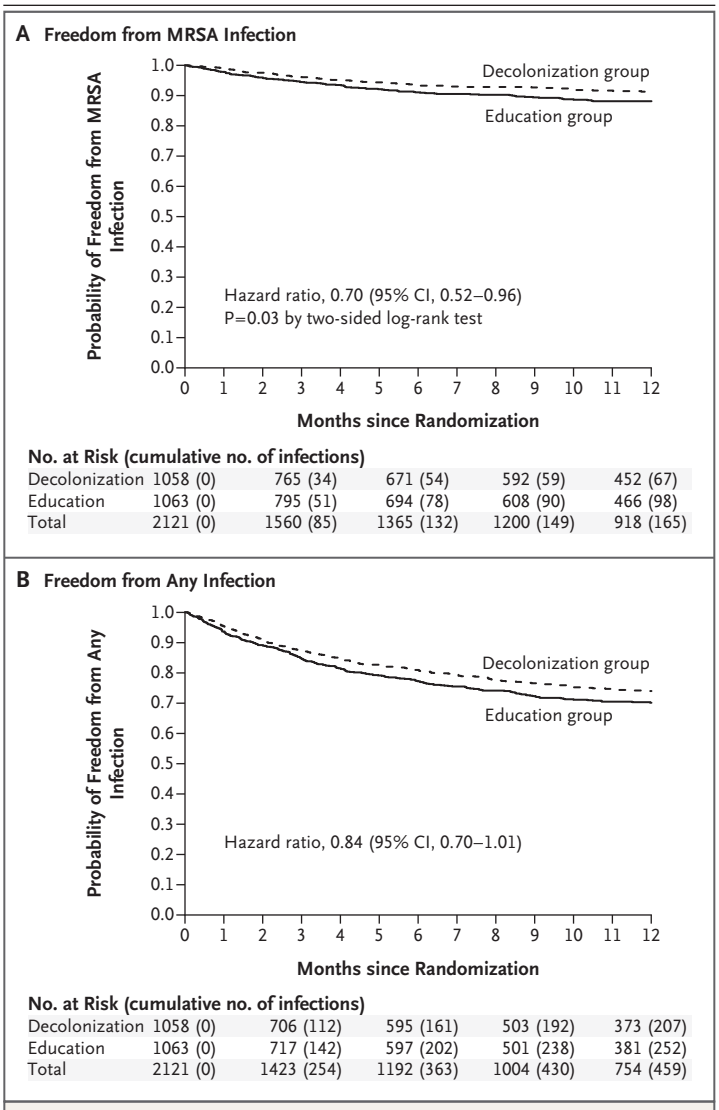

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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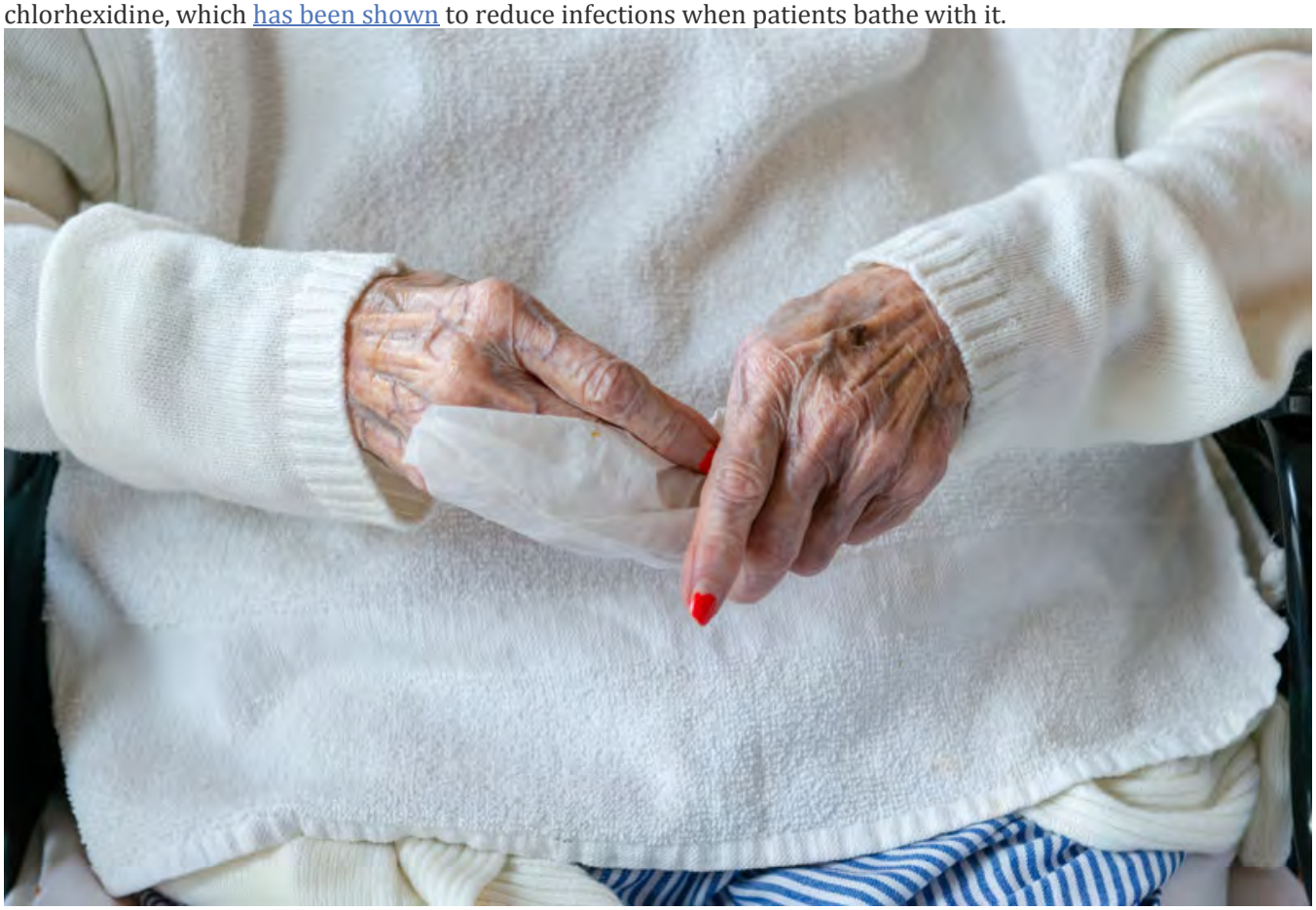
"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.



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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says**.** "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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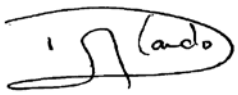
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

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

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

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Post-Acute Infection Prevention Quality Initiative (PIPQI)

Special Board of Directors Meeting

April 16, 2020

David Ramirez, M.D., Chief Medical Officer
Emily Fonda, M.D., MMM, CHCQM, Deputy Chief Medical Officer

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Post-Acute Infection Prevention Quality Initiative (PIPQI) Program

- Since October 2019, 24 participating skilled nursing facilities (SNFs) substitute Chlorhexidine (CHG) soap for liquid soap along with use of Iodophor nasal swabs to decrease skin colonization of Multi-Drug Resistant Organisms, which leads to decreased infection rates.
- CHG has anti-viral, anti-bacterial and anti-fungal properties.
- CHG has been proven to significantly decrease inpatient hospitalization for infection.
- The Centers for Disease Control and Prevention (CDC) has funded a nurse trainer in Orange County and strongly endorses CalOptima's PIPQI, the only such program in the country.
- CalOptima proposes to provide a quarterly incentive ($7,500 per SNF) for program adherence. Following the COVID-19 crisis — as safety permits — will skin test for CHG.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

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. Approve Virtual Care Strategy and Roadmap;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and
3. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications.

Background

As the Coronavirus Disease (COVID-19) continues to spread and threatens lives of many vulnerable populations, the COVID-19 pandemic has created an urgency for CalOptima and other Managed Care Plans (MCPs) to expand their virtual care strategy immediately to ensure timely access to care for our members and support our providers' use of virtual care during the strict social distancing measures while providers experience shortages of Personal Protective Equipment (PPE).

As a result of the COVID-19 pandemic, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements.

At its April 2, 2020 meeting, the CalOptima Board of Directors ratified various COVID-19 mitigation activities. In addition to the approval of Telehealth Policies and Procedures to include temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements in the event of a health-related national emergency, the Board authorized contracting with Virtual Care Consultant Sajid Ahmed of WISE Healthcare to help expedite the deployment of the CalOptima Virtual Care Strategy and Roadmap.

At the same meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

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Discussion

In addition to the actions approved in response to COVID-19 to date, management recommends that the Board authorize the implementation of virtual care services for members and providers with long term implications beyond the COVID-19 pandemic.

Virtual Care Strategy and Roadmap

As the sophistication and simplification of mobile technology has evolved over time beyond telehealth, virtual care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring, and treatment. CalOptima staff cites to an adopted virtual care definition as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care." [1]

CalOptima management plans to continue to use the term "telehealth" to include member materials approved by DHCS in order to be consistent with DHCS All Plan Letter (APL) 19-009: Telehealth Services Policy.

CalOptima's main Virtual Care Strategies include the following elements. Staff will return to the Board to seek authority for approval of implementation of the Virtual Care Strategies through specific vendors and initiatives in the future:

1. Support CalOptima's contracted providers' use of virtual visits during COVID-19 and beyond [all members]
    a. Technical assistance and operational support
    b. CalOptima virtual care team
    c. HIPAA compliant platform(s)
2. Contract with specialty providers with a virtual care focus for CCN members.
    a. Provider(s)/vendor(s) to treat chronic pain/opioid dependency, and provide medication assisted treatment, and eating disorder treatment
    b. Other specialties as available
3. Contract with a vendor offering virtual visits including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions through its own provider network
    a. Integrate with CalOptima website and/or member portal
    b. Technical support for members
    c. Integrate with existing nurse advice line
    d. Develop member smartphone app
4. Contract with a vendor offering eConsults for CCN members and PCP's through CalOptima contracted specialists who wish to participate and/or its own provider network
    a. Technical assistance and operational support for CCN providers
    b. Integrate with CCN UM process
    c. Integrate with CCN provider portal
5. Member texting
    a. Via CalOptima member smartphone app

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With these proposed Virtual Care Strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits:

- Improved member access and convenience;
- Reduced avoidable in person visits to specialists; and
- Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care:

- Improved member experience;
- Augmented network capacity and adequacy; and
- Improved clinical quality outcomes.

As recommended by staff, CalOptima's Virtual Care Strategy proposes a detailed logic model and a work plan which are included in the attachments (refer to Attachment 3 and Attachment 4).

Proposal to Implement Mobile Health Interactive Text Messaging Services

CalOptima currently uses traditional modes of member communication, including telephonic, print and mail. CalOptima staff seeks to strengthen communication outreach opportunities to our members through Mobile Health Interactive Text Messaging Services that will:

- Deliver useful health promotion and prevention messaging;
- Promote healthy behaviors among members;
- Facilitate behavior change;
- Provide support through impactful media;
- Promote wellness and preventive care including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Improve clinical outcomes; and
- Encourage adherence to recommended care practices

CalOptima's RFP minimum requirements for the mobile texting vendor include the following:

- Provide Mobile Text Messaging services to enhance member engagement by supporting CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.
- Deliver technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.
- Ensue that content written at a sixth grade reading level or below so that the information is easy to understand.
- The Platform must be a Health Insurance Portability and Accountability Act (HIPAA) compliant platform with secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data.

Through a Request for Proposal (RFP) process conducted in 2019, CalOptima staff received eight (8) responses and with two finalist texting solution vendors, HealthCrowd and mPulse Mobile (mPulse). CalOptima's Mobile Texting RFP Selection workgroup is recommending that the Board authorize a

contract with mPulse based on it receiving the highest evaluation score (refer to Attachment 5) mPulse specializes in Conversational Artificial Intelligence (AI) solutions for the healthcare industry and promotes improved health outcomes by engaging individuals with tailored and meaningful dialogue. mPulse combines behavioral science, analytics and industry expertise to help healthcare organizations promote their members acquiring healthy behaviors. mPulse is HIPAA and Telephone Consumer Protection Act (TCPA)-compliant, and Health Information Trust (HITRUST) Alliance-certified.

CalOptima's Mobile Texting RFP Selection workgroup is recommending Board authorization for a contract of three years in an amount not to exceed $3,900,000. Based on the CalOptima membership, the estimated annual cost for the contract is approximately $1,000,000, with a separate expense of $80,256 for implementation and set-up. Staff recommends allocating IGT 9 funding not to exceed $3.9 million under the Board-approved focus area of Member Access and Engagement. In addition, staff recommends entering into further negotiations and pursing a contract with mPulse with the assistance of CalOptima's Procurement and Legal Departments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's General and Administrative categories, which are included in administrative loss ratio (ALR).

DHCS requires MCPs to submit a texting program and/or its individual texting campaign approval form to the state. DHCS will review and respond within 60 days of submission of the form (See Attachment 7).

As indicated, staff will return to the Board to seek authority for approval of other elements of the Virtual Care Strategy in the future.

Fiscal Impact

The recommended action to approve the Virtual Care Strategy and Roadmap has no additional fiscal impact for Fiscal Year (FY) 2019-20. Staff will address new virtual care strategies including a vendor offering 24/7 virtual visits and a vendor offering eConsults in future board reports and recommended actions.

The recommended action to select and contract with mPulse, a mobile health interactive text messaging services vendor has no net fiscal impact to CalOptima's operating budget over the proposed project term. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures for the initiative recommended in this report.

Rationale for Recommendation

The recommended actions are important steps in enabling CalOptima to provide additional access to quality care for our members and providers during and after the pandemic.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
2. CalOptima Virtual Care Roadmap Presentation
3. Virtual Care Strategy Logic Model
4. Virtual Care Strategy Work Plan
5. 19-20 Texting RFP Final Team Evaluation Summary Scoring Criteria
6. Texting Program RFP Scope of Work
7. DHCS Texting Program & Campaign Submission Form
8. Board Action dated February 7, 2019, Consider Approval of CalOptima Population Health Management Strategy for 2019
9. Entities Covered by this Recommended Board Action

Reference
1. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

/s/ Richard Sanchez — *04/29/2020*
Authorized Signature — **Date**

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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.

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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.

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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.

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- 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

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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.

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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**

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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

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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.

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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

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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/

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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.

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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.

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

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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

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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

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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;

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- 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)

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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

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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

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- 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.

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- 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

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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.

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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.

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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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(714) 227-4123 CELL
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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

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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

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- 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)

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- 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)

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*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

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Virtual Care Strategy: Road Map to Increase Access to Care

Board of Directors Meeting

May 7, 2020

Sajid Ahmed, CEO WISE Healthcare, CalOptima Virtual Care Expert

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

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On Strategy

"For some organizations, near-term survival is the only agenda item.

Others are peering through the fog of uncertainty, thinking about how to position themselves once the crisis has passed and things return to normal.

Crisis

危機

A time of danger

A time of opportunity

The question is, 'What will normal look like?' While no one can say how long the crisis will last, what we find on the other side will not look like the normal of recent years."

~ Ian Davis, 2009

During the Great Recession

Agenda

- Traditional Barriers to Telehealth
  - Impact of COVID-19 on Regulations
- Virtual Care Definition (Telehealth)
- Virtual Care Modalities
- Virtual Care Roadmap Approach
  - Logic Model: Virtual Care Adoption for CalOptima
- The Future
  - Lifting of Barriers
  - Will They Stay or Will They Go Now?
- CalOptima Virtual Care Strategy

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Traditional Barriers

- Payment and compensation (Provided due to COVID-19)
- Disruptive to current workflow (Yes, post COVID-19)
- Got enough on my plate (COVID-19 response is priority)
- Their convenience, not mine (COVID-19 response is priority)
- New technology, learning (Not really but in some cases)
- Laws, rules, and regulations (Relaxed due to COVID-19)
- Liability questions (Telehealth Insurance now standard)

Impact of COVID-19 on Regulations

- On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic.
- On March 15, Health and Human Services issued a "limited waiver" of Health Insurance Portability and Accountability Act sanctions.
- On March 17, Centers for Medicare & Medicaid Services said it would expand Medicare coverage of telemedicine services.
  - CMS said Medicare will pay providers the same in-person rates for virtual visits with hospitals, doctors and other licensed clinicians […] regardless of the patients' location.
- And on and on ...

Virtual Care Definition

- Beyond telehealth, Virtual Care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring and treatment.

- A recent paper offered the following definition of virtual care:
  - Any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

By Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

Virtual Care Modalities

	Real Time "Synchronous"	**Store and Forward** "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit**  Video/telephonic visit between provider and patient	***e*Visit**  Online exchange (e.g., email or text) between provider and patient
Consults (Provider to Provider)	**Virtual Consult**  Video/telephonic consult between provider to patient's provider	***e*Consult**  Online consult between specialist to patient's local provider

Virtual Care **IS** care provided via phone, email, text, and video.
87% of all diagnostic decisions can be made via Virtual Care

Image courtesy of Sajid Ahmed at WISE Healthcare.

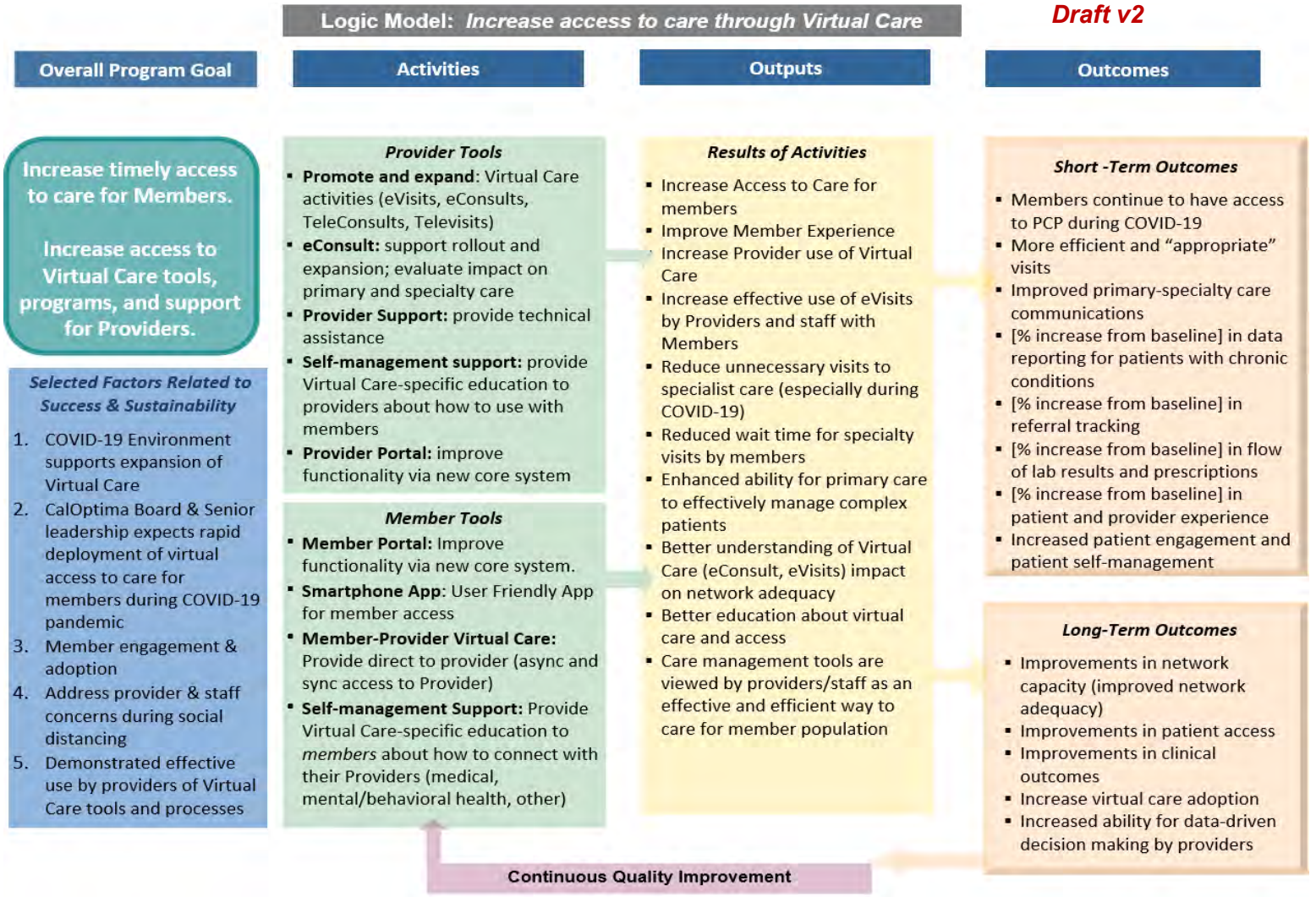
Examples of Virtual Care Modalities

	Real Time / "Synchronous"	Store and Forward / "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit** (Telephone or Video Calls) BRIGHT HEART HEALTH TELADOC MDLIVE	***e*Visit** (Emails &Text Messages) text4baby mPulse mobile CAPTUREPROOF
Consults (Provider to Provider)	**Virtual Consult** • Live Case-based Learnings • Live remote monitoring eICU Program Project ECHO	***e*Consult** • Direct email via EHR • Health Information Exchanges SAFETY NET CONNECT

Examples only. CalOptima does not endorse specific vendor.

Image courtesy of Sajid Ahmed at WISE Healthcare.

Logic Model: Increase Access to Care Through Virtual Care



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MCP Guidance for Use of Virtual Care by Members and Contracted Providers (cont.)

Member

- Member will use the provider-given cell number to **text** the provider with their reason to request a virtual visit (chief complaint, medical concern, follow-up visit).
- Provider and member will communicate back and forth using text messages (member to provider eConsult).
  - If member concerns are resolved at this stage, no further action is necessary.
- If the provider deems a phone **call** necessary, text messages will be used to coordinate the call.
  - With all stages of communication, the provider can use any location (home) as a responding site.
- If after the phone conversation the provider deems that a **video call** would be necessary, text messages are used to coordinate a video call.

Disclaimer: MCPs do not recommend, endorse, nor sponsor specific messaging applications nor cellular providers.

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MCP Guidance for Use of Virtual Care by Members and Contracted Providers

Due to COVID-19, select federal and state virtual care restrictions have been lifted — the use of smartphones and other communication applications to facilitate dialogue between providers and members has been approved. This communication will be allowed and reimbursable per CMS and DHCS directives.

Protocol: Providers and members can text, call and video call to coordinate and manage care to and from any location (home).

Providers

Providers will select a SMS text enabled cell number that can be used by patients. If possible, this can be the provider's primary cell number or:

- An app can be used that allows the provider to receive multimedia messages (WhatsApp, iMessage, Line, GroupMe, Google Duo, Arya, etc.)
- Providers can obtain a new cell number to be used for this purpose through any cellular carrier

Providers can designate a staff member to monitor communication with this number (possibly through a group chat) and facilitate member provider coordination.

Every Cloud Has a Silver Lining...

- It took the COVID-19 pandemic to
  - Waive or relax most health care regulations to ensure that patients get the best possible care at the lowest possible cost, when and where they need it.
- The federal rules and regulations providing limited waivers due to the COVID-19 pandemic are:
  - **HIPAA sanctions waiver** — waiving patient consent
  - **Telemedicine reimbursement** — provided for all virtual care
  - **Physician scope of practice** — lets "all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas"
  - **Elective surgery guidance** — limits elective surgical and dental procedures for adults
  - **Quality reporting requirements** — suspended or extended

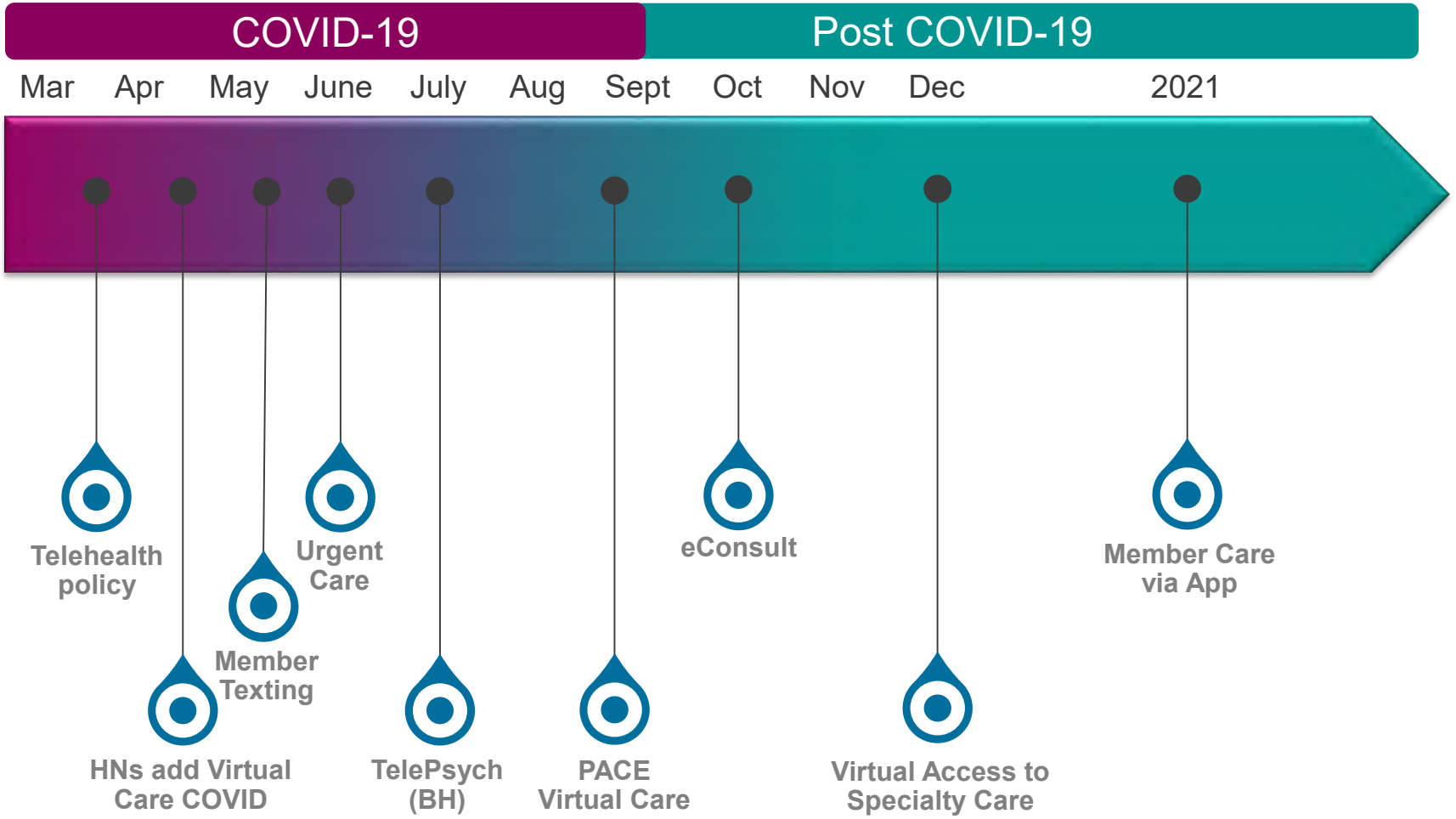
Regulations: Will They Stay, or Will They Go?

- The outbreak shined a light on all the rules and regulations that the U.S. health care system operates under.
- Regulations and rules shown to be impediments to safe, effective, convenient, accessible and affordable care for members.
- CalOptima's long term Virtual Care strategy provides a roadmap to navigate the future in providing low-cost, high quality, timely access to care.

Key Takeaways

- COVID-19 morphed virtual care into a powerful resource that enables the disruption of health care delivery.
- In-person care and virtual care are to be treated the same as appropriate. With virtual care expected to be the primary modality to access care in the future.
  - The “new normal”
- Leadership support is needed from the Board, Chiefs, physician champions, and Health Networks to achieve success and meet the challenges and opportunities of the health care “new normal”

High Level Virtual Care Roadmap



CalOptima Virtual Care Strategy (Road Map)

Board of Directors Regular Meeting
May 7, 2020

David Ramirez, M.D., Chief Medical Officer

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

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Virtual Care Guiding Principles

- 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;
- Leverage existing delivery model where possible;
- To be proactive in seeking out opportunities to innovate; and
- To provide technology-agnostic solutions.

Proposed Initial Virtual Care Strategy: All Members (HN/CCN/COD)

Member to Provider		
Goals	**Use Existing Network Providers**	**Contract Vendor(s) to support limited scope of services during COVID-19**
Tasks	• Leverage existing capabilities • Guidance • Technical support • Technology agnostic	• Member self-referral via Member Portal (web) • Urgent care • Prescription management • Access to Behavioral Health
Time	Q1 2020	Initiate Contract in Q2–Q3 2020
Action	**Update Telehealth Policy (completed)**	**RFP (IGT 9) for vendor(s)**

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Proposed Initial Virtual Care Strategy: CalOptima Community Network & CalOptima Direct

	Member to Provider	Provider to Provider
Goals	**Provide Virtual Care:** Member access to Provider Group(s), eVisits to primary care and specialist services	**Implement eConsult (CCN)** (Provider to Provider) per DHCS APL 19-009 to provide eConsult as a covered benefit
Tasks	• Support existing physical primary care providers and specialists • Behavioral Health Services (for all members) • Expand specialty providers with a virtual care focus	• Prior Authorization process modified to allow eConsult to replace authorization • Make available to PACE as well • Provider self-service and submit authorization via Provider Portal and eConsult
Time	Selection in Q3 2020	Contract in Q4 2020
Action	**Evaluate telehealth providers/groups**	**Develop plan to implement eConsult**

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Virtual Care Roadmap Q2–Q4

High Level Activities

1. Member engagement approaches, app support and tools
2. Continue activities to support COVID-19 related items
3. Virtual Care technical platform for PACE
   - Facilitate provider-member virtual visits
4. Investigate and implement provider support and technical assistance
5. In progress:
   - Virtual Care Strategy and Roadmap
   - CalOptima Virtual Care Team
6. Expand specialty providers with a virtual care focus
   - Behavioral health and other specialties

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Virtual Care Roadmap Q2–Q4 (cont.)

High Level Activities (cont.)

7. Offer 24/7 virtual visits (after-hour access)
   - Acute non-emergency medical conditions
   - Behavioral health conditions
8. Investigate and implement CalOptima member engagement access via member portal app
   - APIs to virtual visits, eVisits, secure messaging
9. Plan and launch eConsult/eReferral program for CCN
10. Member texting
    - E.g. Text For Baby, notifications, alerts via CalOptima Smart app, e.g. IEHP Smart Care app
11. RFP for member direct to provider access
    - Member to provider

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Logic Model: *Increase access to care through Virtual Care*

Draft v2

Overall Program Goal	Activities	Outputs	Outcomes

Increase timely access to care for Members.

Increase access to Virtual Care tools, programs, and support for Providers.

Selected Factors Related to Success & Sustainability

1. COVID-19 Environment supports expansion of Virtual Care
2. CalOptima Board & Senior leadership expects rapid deployment of virtual access to care for members during COVID-19 pandemic
3. Member engagement & adoption
4. Address provider & staff concerns during social distancing
5. Demonstrated effective use by providers of Virtual Care tools and processes

Provider Tools

- **Promote and expand**: Virtual Care activities (eVisits, eConsults, TeleConsults, Televisits)
- **eConsult:** support rollout and expansion; evaluate impact on primary and specialty care
- **Provider Support:** provide technical assistance
- **Self-management support:** provide Virtual Care-specific education to providers about how to use with members
- **Provider Portal:** improve functionality via new core system

Member Tools

- **Member Portal:** Improve functionality via new core system.
- **Smartphone App**: User Friendly App for member access
- **Member-Provider Virtual Care:** Provide direct to provider (async and sync access to Provider)
- **Self-management Support:** Provide Virtual Care-specific education to *members* about how to connect with their Providers (medical, mental/behavioral health, other)

Results of Activities

- Increase Access to Care for members
- Improve Member Experience
- Increase Provider use of Virtual Care
- Increase effective use of eVisits by Providers and staff with Members
- Reduce unnecessary visits to specialist care (especially during COVID-19)
- Reduced wait time for specialty visits by members
- Enhanced ability for primary care to effectively manage complex patients
- Better understanding of Virtual Care (eConsult, eVisits) impact on network adequacy
- Better education about virtual care and access
- Care management tools are viewed by providers/staff as an effective and efficient way to care for member population

Short -Term Outcomes

- Members continue to have access to PCP during COVID-19
- More efficient and "appropriate" visits
- Improved primary-specialty care communications
- [% increase from baseline] in data reporting for patients with chronic conditions
- [% increase from baseline] in referral tracking
- [% increase from baseline] in flow of lab results and prescriptions
- [% increase from baseline] in patient and provider experience
- Increased patient engagement and patient self-management

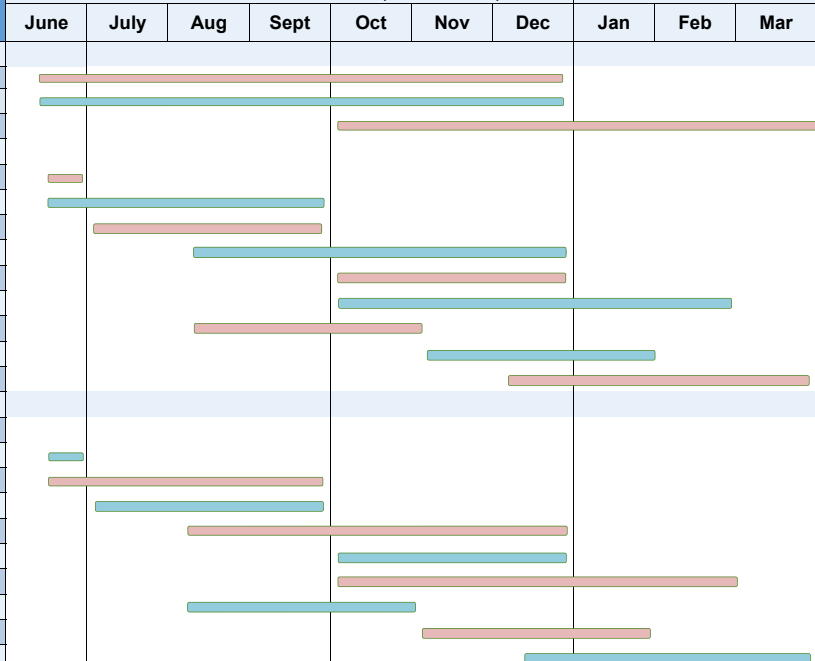
Long-Term Outcomes

- Improvements in network capacity (improved network adequacy)
- Improvements in patient access
- Improvements in clinical outcomes
- Increase virtual care adoption
- Increased ability for data-driven decision making by providers

Continuous Quality Improvement

Cal Optima Virtual Care High Level Workplan

2020 - Phase IIA - Foundation (New Fiscal)



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TEAM SUMMARY SCORES

RFP 19-020 – Mobile Text Messaging Services

Proposals Scores

Vendor Name	Score
mPulse	3.57
HealthCrowd	3.45
Bluespire	3.63
TigerConnect	3.32
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

Interview Scores

Vendor Name	Score
mPulse	4.30
HealthCrowd	4.18
Bluespire	3.73
TigerConnect	2.51
Medecision	0.00
MTX Group Inc.	0.00
Variedy	0.00
Care3	0.00

Overall Scores

Vendor Name	Score
mPulse	3.94
HealthCrowd	3.81
Bluespire	3.68
TigerConnect	2.92
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

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CalOptima
A Public Agency
Better. Together.

M E M O R A N D U M

DATE:	May 22, 2019
TO:	Pshyra Jones, Ashley Young, Kelly Rex-Kimmet, Belinda Abeyta, Albert Cardenas, Erica Neal, Christine Sisil, Adriana Ramos, Edwin Poon, Diane Ramos, Lisa Ha
FROM:	Maria Medina, CPPB
SUBJECT:	RFP 19-020 – Mobile Text Messaging Services

EVALUATION PROCESS INSTRUCTIONS:

IMPORTANT….If you are contacted by any vendor regarding this RFP process, please do not speak with this vendor and forward all calls to my attention.

Step One: ***Review all Proposals***. Evaluation committee members were provided with copies of each RFP response to begin their individual review of the Proposals. **Take notes, make comments and/or prepare questions for discussion.** Do not score at this point.

Step Two: ***Determine status***. Make an initial determination as to whether each Proposal is "responsive" or "non-responsive." A "responsive" proposal conforms in all material respects to the RFP. A proposal may be deemed "non-responsive" if essential required information is not provided, the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP, or the proposal is clearly not within the scope of the project described and required in the RFP. *Extreme care should be used when making this decision because of the time and cost that a vendor has put into submitting a proposal. If a proposal is determined to be "non-responsive," it will not be considered further. The Purchasing department will make the final determination of responsiveness. If a determination of "non-responsiveness" is made, written justification must be provided for this conclusion.*

Step Three: ***Score proposals.*** Committee members should **INDIVIDUALLY** score the proposals based on the criteria established within the RFP. Please send me your individual scores by **12:00 Noon, June 5, 2019.** I will prepare a summary team score for all scorers.

Step Four: ***Evaluation Committee Meeting***. Once the proposals have been evaluated and scored by the individual committee members, the entire committee will meet to discuss the proposals and arrive at the final scoring. The committee should discuss all aspects of the proposals so that there is a "unified understanding" of the criteria and corresponding responses. Individual scores may be adjusted at this point based upon discussion. If any of the scores change I will prepare a new summary team rating. The highest score on the Summary Team score will be awarded the business.

Step Five: ***Discussion/Negotiation.*** This step is optional. If the committee is unsure of certain items or issues included in the RFP response, it may request further clarification from the vendor. The Purchasing department will distribute clarification questions to applicable vendor/s. Upon receipt of the vendor responses, the Purchasing department will distribute to the committee members.

Step Six: ***Best and Final Offer.*** This step is optional. A letter asking the vendors to submit a "Best and Final Offer" may be issued by the Purchasing department at the request of the evaluation committee. Once a "Best and Final Offer" is received, the committee will evaluate it in the same manner as the original Proposal.

Step Seven: ***Recommendation and Review.*** After the final scores from the above steps are tallied, the Purchasing department will contact the successful vendor and initiate the agreement process. Upon contract execution, the Purchasing department will notify the remaining vendors, informing them of our decision to award the business elsewhere.

PROPOSAL RATING INSTRUCTIONS:

The attached proposal evaluation form is to be used to initially rate and score proposals. Please enter your scores in the "raw score" fields of the Evaluation Score Sheet. *Please forward to my attention, an electronic version of your completed Evaluation Score Sheet no later than* ***12:00 Noon, June 5th****. The initial results will be presented at the meeting and will form the basis of our discussion.*

- EVALUATION CRITERIA

  Evaluation criteria and respective weights are as follows:

Evaluation Criteria	**Raw Possible Points**	**Weight Factor**	**Total Possible Score**
Letter of Transmittal Requirements, Proposal Organization, completeness of response	5	10%	0.50
Process: Vendor can perform all aspects of the Contract, knowledge of industry, proper qualifications, can handle our size and needs	5	25%	1.25
Related experience: Years, Worked with Vendors similar to CalOptima, References	5	20%	1.00
Account Team: Qualifications, Location, Experience	5	15%	0.75
Price	5	20%	1.00
Contract Changes (Purchasing Only)	5	10%	0.50

  With the four different evaluation criteria, there is a total of 30 "raw points" available for each Proposal. Each evaluation criteria has been weighted in proportion to its perceived value to the overall score.

  Each criterion should be rated separately from the others. In other words, if vendor "A" appears highly capable of effectively completing the project/providing the service, has very good qualifications and related experience, but in your opinion, does not have competitive rates, you should not downgrade your score for the first two criteria as punishment for not doing well on the other criteria categories. It is perfectly acceptable to give vendor "A", a higher score for the first two criteria, and a lower score on the other applicable criteria.

  The Evaluation Team will only need to input their scores in the rows entitled "raw score" of the attached electronic Evaluation Score Sheet.

- PROPOSAL CRITERIA RATINGS (0-5)

  Please rate each Proposal on a scale of 0-5 for each evaluation criteria. This scale and the meaning of the ratings are as follows:

  5 - Outstanding - far exceeds minimum requirements, offers prospects of extremely high-quality work product.

4 - Very Good - exceeds minimum requirements, offers prospects of very high work product.

3 - Good - meets minimum requirements, although there are deficiencies which may result in some flawed work products.

2 - Barely adequate - several deficiencies which may result in flawed work product.

1 - Deficient - does not meet requirements, poses virtual certainty of high risk of flawed products and generally inadequate performance.

0 - Totally non-responsive and noncompetitive to the RFP.

- SCORE (Maximum 5 points)

  Raw Possible Points Evaluation Rating x Weight/Factor = Total Possible Score
  The maximum weighted score for any given Proposal is 5 points.

Reminder….. The EVALUATION MEETING is scheduled for June 6th from 1:00pm – 2:00pm in conference room 802-S

I can be reached on ext. 8659 for any questions. Thank you.

Scope of Work

I. OBJECTIVE

CalOptima is seeking a CONTRACTOR to provide Mobile Text Messaging services to enhance member engagement. The successful Offeror must support CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.

The successful Offeror will provide technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.

II. MEMBERSHIP

CalOptima's membership is provided for reference only.

CalOptima Membership*

Program	Description	Members
Medi-Cal	California's Medicaid Program for low-income children, adults, seniors and people with disabilities	689,641
OneCare Connect	Medicare-Medicaid Plan for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination	14,104
OneCare	Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal	1,417
PACE	Program of All-Inclusive Care for the Elderly for older adults, providing comprehensive health services through the CalOptima PACE center	394

**Membership Data as of January 31, 2020*

III. REQUIREMENTS

A. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **The Contractor shall be required to sign a Business Associate Agreement (BAA) prior to the commencement of the Contract.**

B. **MOBILE TEXT MESSAGING**

1. Text Campaign Strategy

   a. Successful Offeror's mobile text messaging services must be able to support specific initiatives to help increase member engagement and communications between CalOptima andthe member and. Please describe and/or provide any

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samples to demonstrate how the Successful Offeror can support the following with targeted texting strategies:

- Quality Improvement (i.e. preferable experience in assisting health plans with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
- Health Plan Navigation Support (i.e. providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
- Surveys to measure member satisfaction with CalOptima's services

2. Text Messaging Features
   a. Please describe the messaging features that are supported by the Successful Offeror. At minimum, they should include:
      - Text blasting/bulk messaging
      - Two-way text messaging
      - Tailored or personalized text messages
      - Automated responses
      - Keywork responses
      - Conditional branch logic (allow for keyword and automated responses based on predefined algorithm)
      - Message scheduling/staggering
      - Message queuing
      - Active links
      - Voting and polling
      - Short codes
      - Unicode support

3. Content

   a. Content must be written at a sixth-grade reading level or below to ensure the information is easy to understand. Please provide any details related to content development, required approvals, and customization options.

4. Enrollment

   a. Successful Offeror shall have policies and proecuedres for managing the users opt-out/opt-in and text preferences.

   b. Successful Offeror must be able to support CalOptima with identifying mobile numbers and land line numbers to distinguish users who are able to receive text messages.

IV. DATA EXCHANGE, SECURITY, AND SYSTEM INTERFACE REQUIREMENTS

A. The Successful Offeror must have a Health Insurance Portability and Accountability Act (HIPAA) compliant platform and secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data. Please share the process, policies and/or procedures Successful Offeror will follow to ensure HIPAA regulations are met and certified as HIPAA compliant.

B. Successful Offeror shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load.

C. Successful Offeror must ensure that all data is kept for ten (10) years at minimum.

D. Successful Offeror agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful transition files at no additional cost.

V. CULTURAL AND LINGUISTICS

A. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic. Successful Offeror shall have ability to support mobile text messaging services in English and Spanish, at minimum. Please list any other languages that are supported by the Sum.

VI. REPORTING

A. Successful Offeror's reporting mechanisms should be able to provide real-time updates of text message delivery and campaign performance. Describe what information is captured on these reports.

B. Summary reports shall be provided at the conclusion of each text campaign that measures performance and outcomes. Describe the report features and the data elements that are captured.

C. Reports should be in a format that allows data to be integrated into CalOptima systems. How will data be shared with CalOptima (i.e. web portal, secure email, FTP transfer, etc)?

D. Does the Offeror include any analysis in the standard reporting package?

E. All offerors shall provide a sample copy of the reports with its proposals.

VII. SERVICE LEVEL AGREEMENT (SLA)

What Service Level Agreements and warranties does your company provide? Please provide detail levels and metrics. Include a specific time element offered.

VIII. IMPLEMENTATION SCHEDULE

Offeror shall provide an implementation timeline, including benchmarks and milestones as part of its response.

IX. PRICING MODEL

Offeror shall provide pricing model/structure for implementation, services provided and any other fees CalOptima may incur.

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TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New Member Orientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_Multiple Campaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan: _____ Date: _____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

   _____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI and meet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federal law and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes

   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes

   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes

   ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] text messaging program, [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

3. Consider Approval of CalOptima Population Health Management Strategy for 2019

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Consider approval of the CalOptima Population Health Management Strategy for 2019.

Background

The National Committee for Quality Assurance (NCQA) continuously assesses the health care landscape, as well as pending regulations, to enhance accreditation standards annually. Effective July 1, 2018, NCQA implemented a significant change by creating a new Population Health Management (PHM) Standards section (see Attachment 2). Concurrently, NCQA eliminated the Disease Management standards, moved Complex Case Management (CCM) Standards from the Quality Management & Improvement Standards (QI) section, and Wellness and Prevention Standards from the Member Connections Standards (MEM) section to the PHM section. The PHM section also included new standards requiring health plans to provide Delivery System Supports, such as providing transformation support to the primary care practitioners. The comprehensive PHM Strategy is the first structural requirement of the new standard set. In preparation for the next NCQA re-accreditation and onsite audit scheduled for July 11-12, 2021, CalOptima must start implementing the PHM Strategy with appropriate resource alignment starting on May 24, 2019 upon Board approval.

Discussion

The intent of the CalOptima PHM Strategy for 2019 is to develop a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management 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 year one approach of the CalOptima PHM Strategy is to align current and new programs (e.g., Bright Steps, Behavioral Health Integration, Whole-Child Model, Complex Case Management, and Health Management Programs, etc.) to the new PHM framework leveraging internal and external population health needs assessment findings to date. The PHM plan of action as part of the Quality Improvement (QI) Work Plan is updated annually through the comprehensive annual QI Program and Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflect the changing demographics and local population needs of the Orange County community.

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The PHM Strategy addresses four focus areas:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across all settings
4. Managing multiple chronic conditions.

Building upon the current high touch Model of Care and expanding its relevant care components to provide access to quality health care services to a broader member population, the CalOptima PHM Strategy proposed innovative ways to provide members with access to quality health care services leveraging secured virtual technology. CalOptima will be testing the feasibility of various telehealth use cases, ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in member's home.

Additionally, the PHM Strategy proposed new strategies to support providers in the delivery system transformation.

1. Practice Site Transformation - Develop CalOptima Quality Improvement nursing expertise to serve as Quality Advisors or Practices Facilitators to provide individualized technical assistance to improve member experience and patient safety at the practices starting with high volume safety net community centers.
2. Expand Provider Coaching and Leadership Development - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices with high incidences of Quality of Services (QOS) grievances.

Fiscal Impact

There is no additional fiscal impact for the recommended action to approve the CalOptima PHM Strategy for Calendar Year 2019. The Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018, included funding to start implement the PHM Strategy by May 2019.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Population Health Strategy with the NCQA's new standards to provide integrated quality healthcare services to CalOptima's population at large, including those members who are currently healthy and low emerging risk. The timely implementation of the PHM Strategy by May 2019, will position CalOptima well to achieve NCQA re-accreditation aiming for Excellence accreditation status in 2021.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachments

1. CalOptima Population Health Management (PHM) Strategy for 2019
   a. 2018 NCQA PHM Standards
2. 2019 NCQA PHM Standards and Guidelines
3. PowerPoint Presentation to Board of Directors' Quality Assurance Committee: CalOptima PHM Strategy - 2019 Overview

/s/ Michael Schrader *1/30/2019*

Authorized Signature **Date**

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CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

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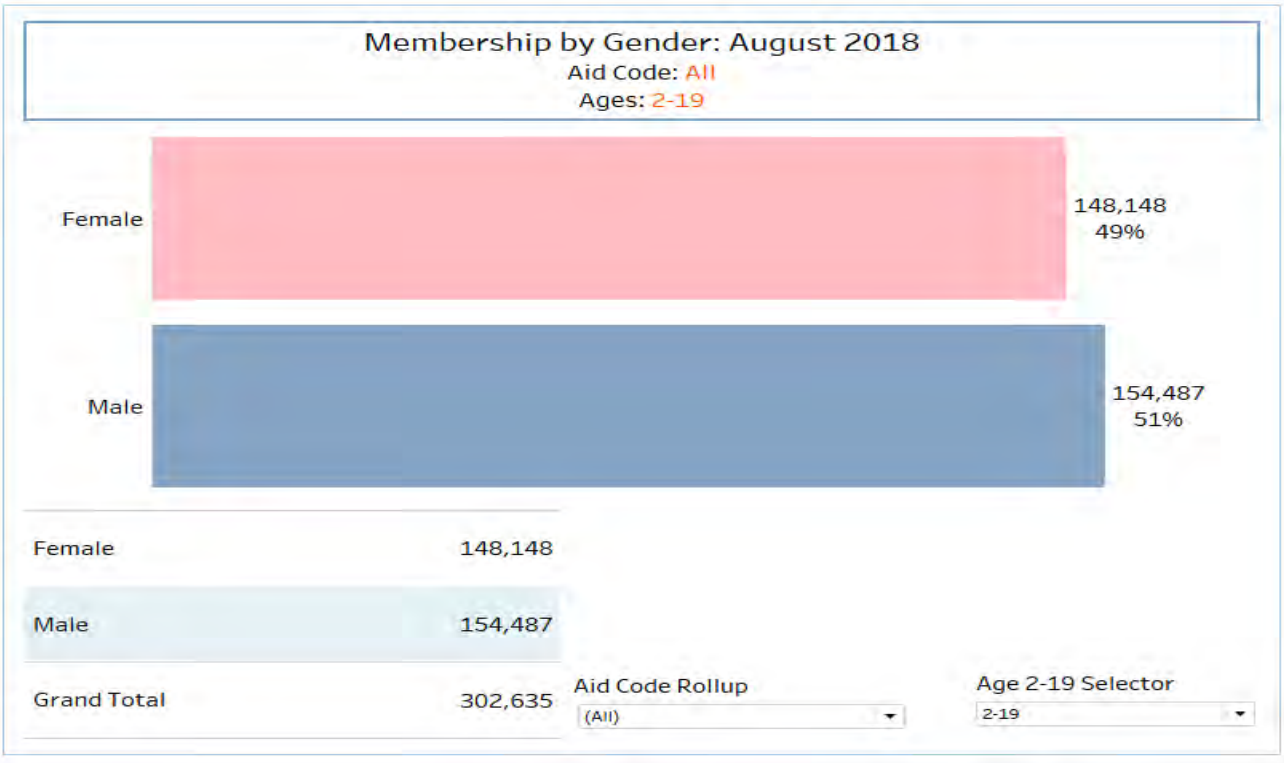
effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is 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. 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. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
      - The 2016 Orange County Community Indicators Report
      - The 2017 Conditions of Children in Orange County Report
      - Children eligible for California Children's Services (CCS) Report from the county CCS Program
      - Prenatal Notification Report (PNR)
  - **Data Integration [PHM2 A]**
    - CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
      - Member data from the Department of Health Care Services (DHCS)
      - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
      - Encounters data from contracted health networks
      - Pharmacy claims
      - Laboratory claims and results from Quest and LabCorp
      - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

- **CalOptima Population and Sub-Population Segments [PHM2 B]**
  - In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*
    - *Ages 2–19*



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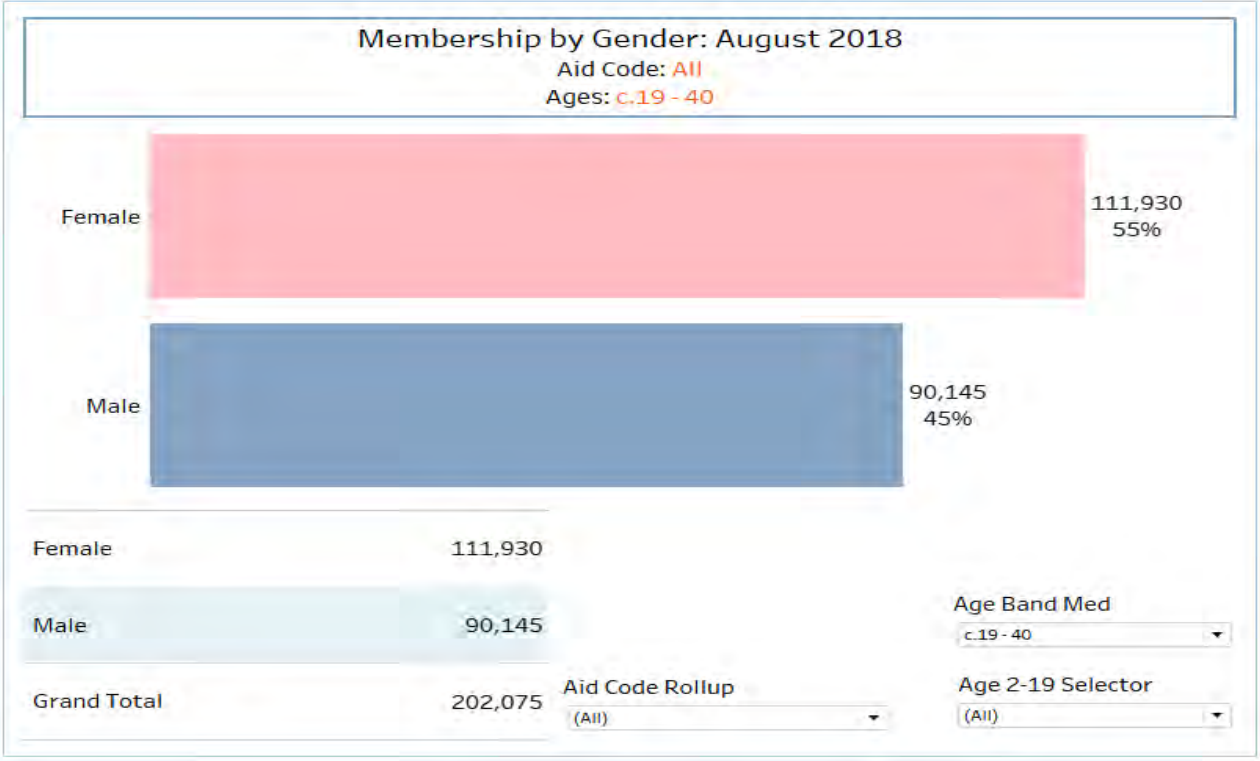
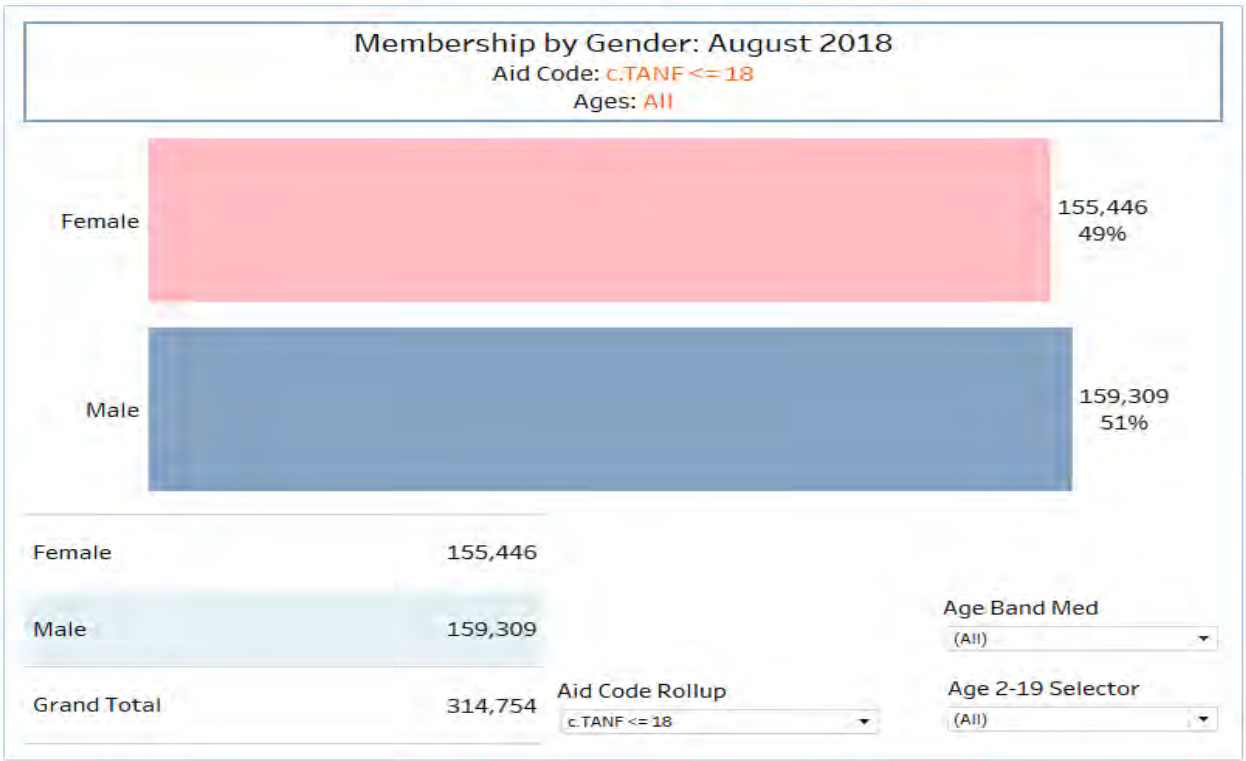
- *Adults 19–40*



- *TANF (<18 Non-SPD)*



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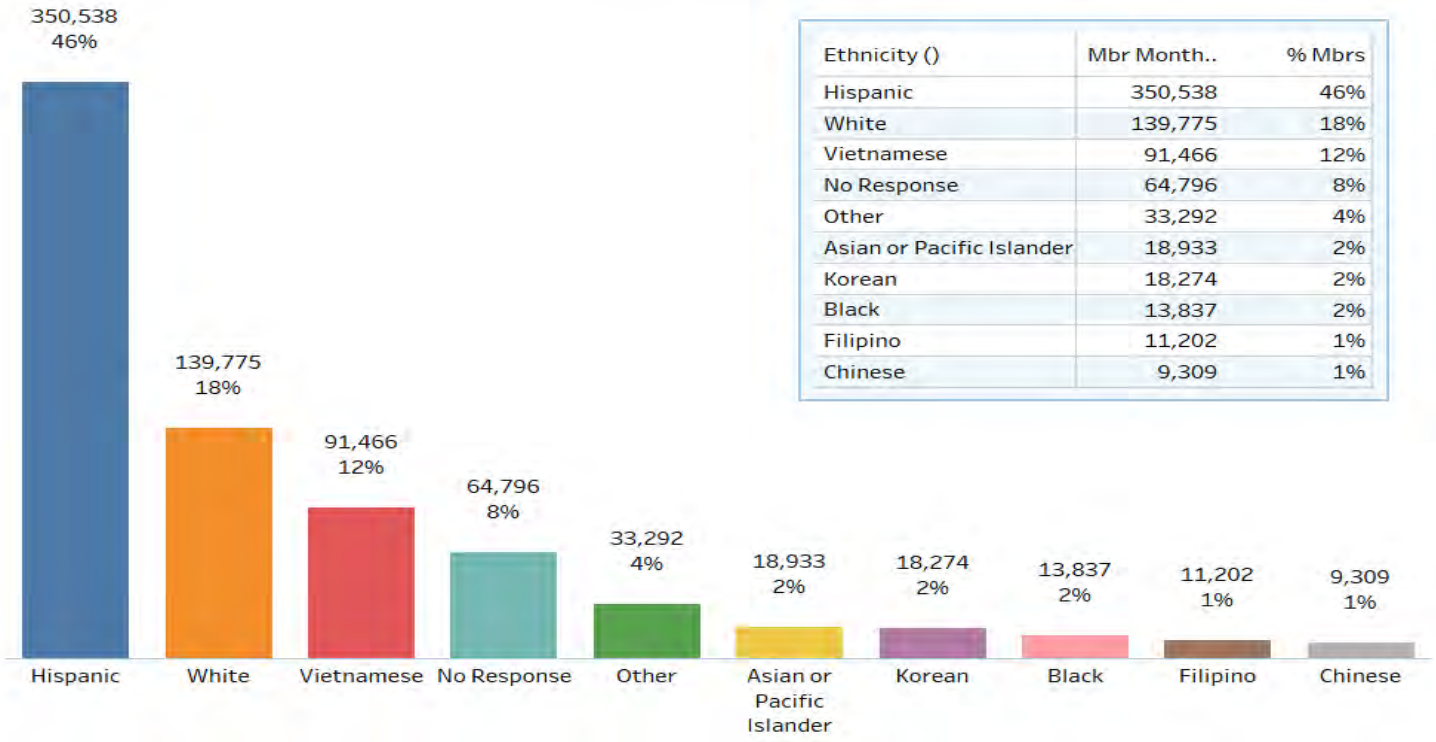
- *Ethnicity*

CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



Ethnicity ()	Mbr Month..	% Mbrs
Hispanic	350,538	46%
White	139,775	18%
Vietnamese	91,466	12%
No Response	64,796	8%
Other	33,292	4%
Asian or Pacific Islander	18,933	2%
Korean	18,274	2%
Black	13,837	2%
Filipino	11,202	1%
Chinese	9,309	1%

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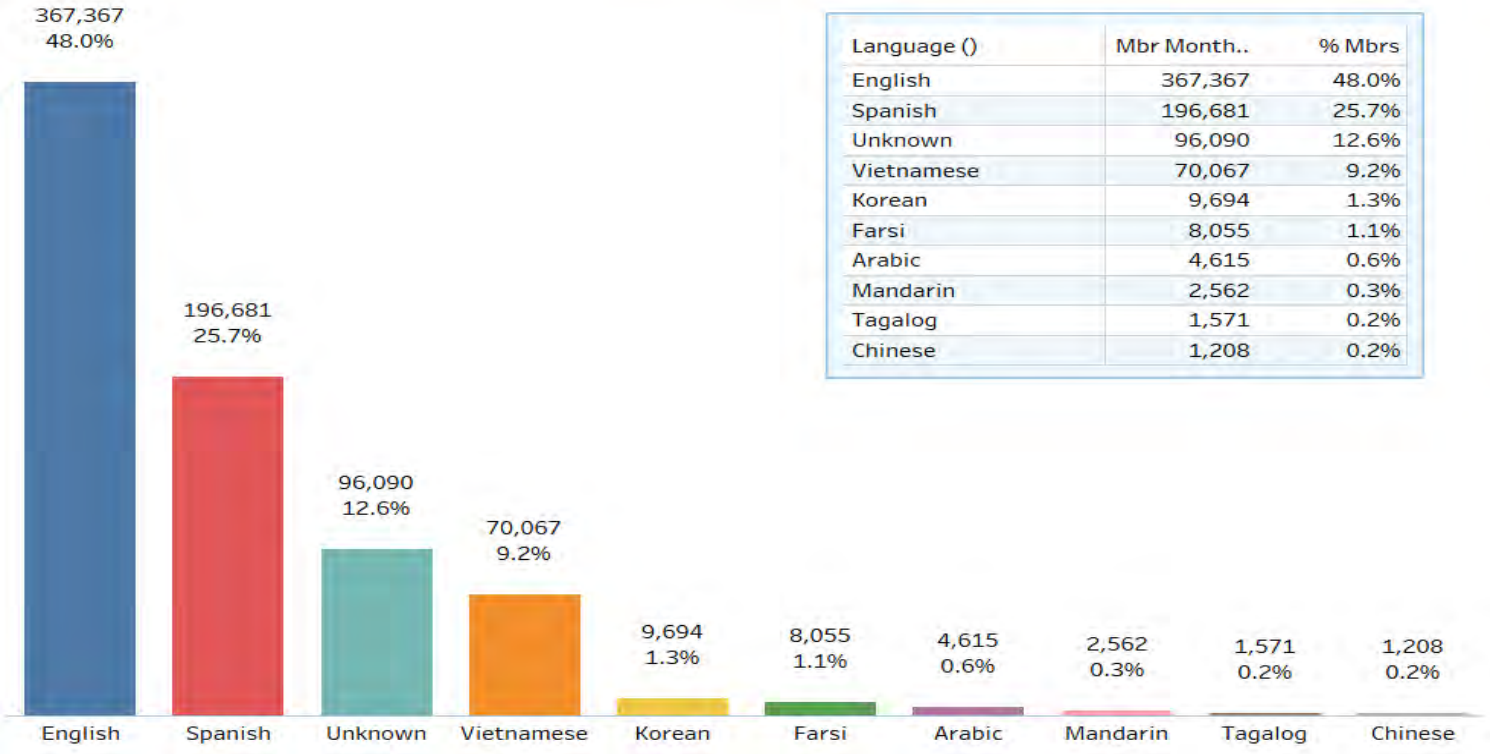
- *Language*

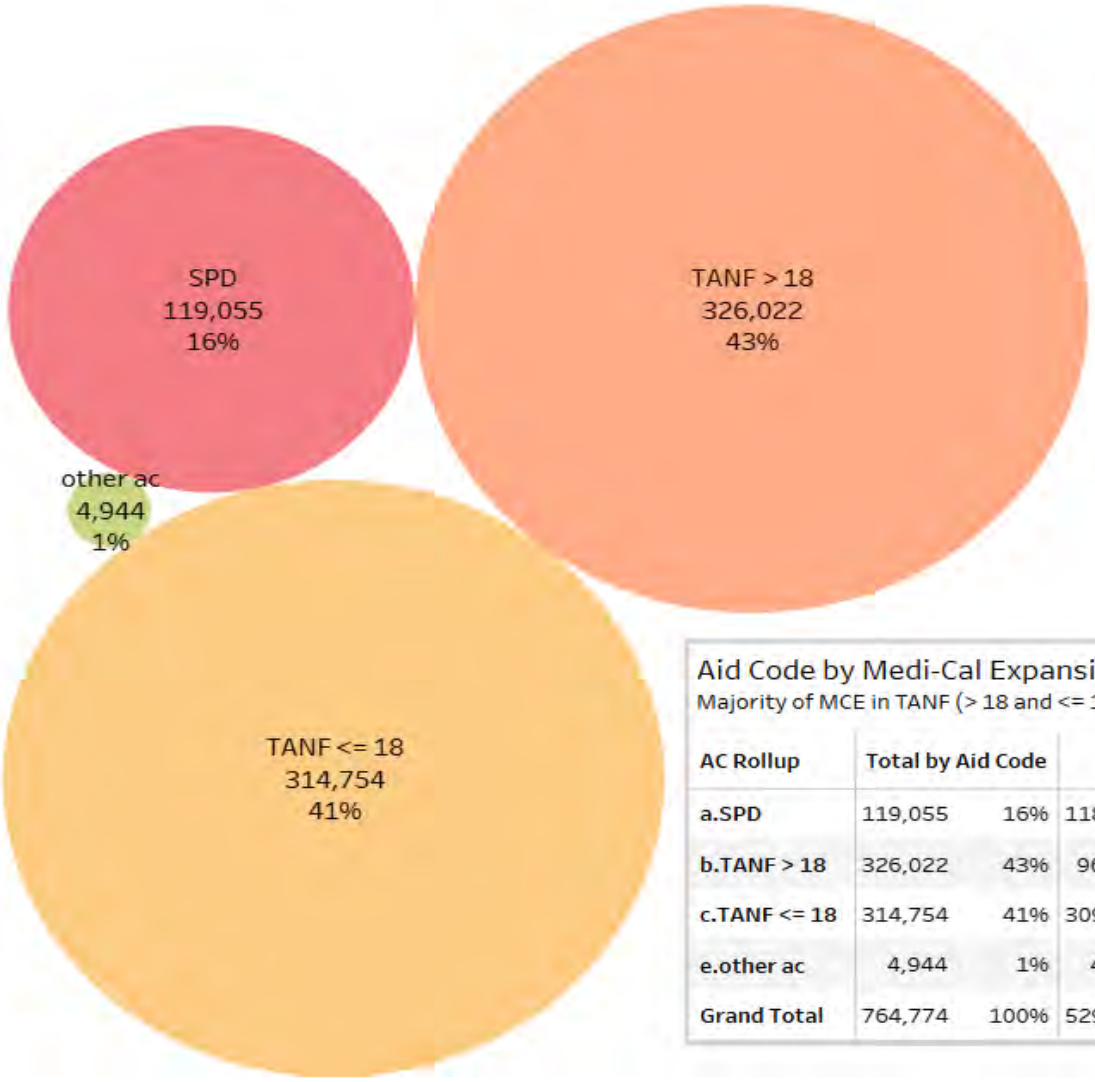
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



Language ()	Mbr Month..	% Mbrs
English	367,367	48.0%
Spanish	196,681	25.7%
Unknown	96,090	12.6%
Vietnamese	70,067	9.2%
Korean	9,694	1.3%
Farsi	8,055	1.1%
Arabic	4,615	0.6%
Mandarin	2,562	0.3%
Tagalog	1,571	0.2%
Chinese	1,208	0.2%

- *By Aid Code*

Membership by Aid Code: August 2018

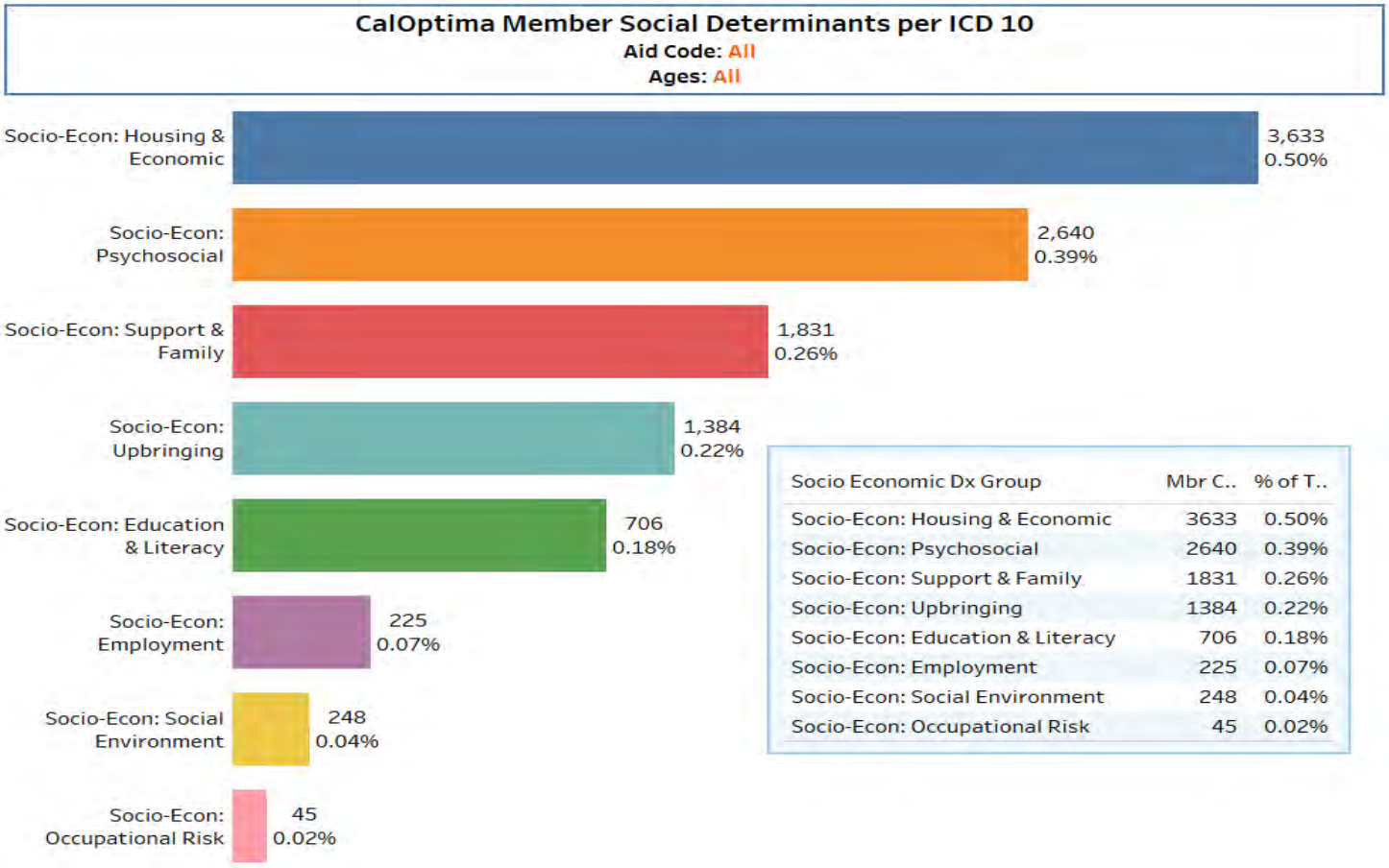


Aid Code by Medi-Cal Expansion (MCE)

Majority of MCE in TANF (> 18 and <= 18) aid codes

AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SPD	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- *Social Determinants*



Socio Economic Dx Group	Mbr C..	% of T..
Socio-Econ: Housing & Economic	3633	0.50%
Socio-Econ: Psychosocial	2640	0.39%
Socio-Econ: Support & Family	1831	0.26%
Socio-Econ: Upbringing	1384	0.22%
Socio-Econ: Education & Literacy	706	0.18%
Socio-Econ: Employment	225	0.07%
Socio-Econ: Social Environment	248	0.04%
Socio-Econ: Occupational Risk	45	0.02%

➢ **Other Sub-Populations**
- Women during pregnancy
- Children with obesity
- Children with California Children's Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

❖ **Population Assessment [PHM2 B]**

➢ CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

- **Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]**
  - **Bright Steps — Improve Prenatal and Postpartum Care**
    - **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
      - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
      - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
    - **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
    - **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
    - **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

- **Shape Your Life — Prevent Childhood Obesity**
  - **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for following Children/Adolescents (WCC) measures year-over-year:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
  - **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
  - **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
  - **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

- **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**
  - **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**
    - **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
      - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
      - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
      - Reduce ED and IP rates by 3% for program participants in 2018
    - **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
- Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
- Exclusion Criteria:
  - Ineligible CalOptima Members
  - Members Identified for LTC or diagnosed with Dementia
  - Members Delegated to Kaiser

- **Description of Programs or Services:** CalOptima's Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima's population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
- **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*

➢ **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**

- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- **Target Population:** Members with diagnosis of opioid substance abuse disorder
- **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
- **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

- **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**
  - **Behavioral Health Treatment (BHT) Services**
    - **Goal:** Establishing appropriate program baseline in 2019
    - **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
    - **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
    - **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

  - **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**
    - **Goals**: Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
    - **Target Population:** Medi-Cal adults and children accessing primary care.
    - **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
    - **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

- **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**
  - **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**

- **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
  - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to ≥37.0% (2018 Baseline = 33.3 %)
  - Improve Immunization for Adolescents with CCS eligible conditions to ≥ 50.0% (2018 Baseline = 45.33%)
- **Targeted Population:** Children with CCS Eligible Conditions
- **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.
  Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

➢ **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**
- **Goal:** Establishing baseline measures in 2019
  - Member Engagement Rate
  - Inpatient Readmissions
  - Emergency Department (ED) Visits
- **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
  - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;
  - Meet specified acuity/complex criteria

- Eligible members consent to participate and receive Health Home Program services.

- **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- **Activities:** Core services as defined by DHCS are detailed below.
    - Comprehensive care management
    - Health promotion
    - Care coordination
    - Individual and family support services
    - Comprehensive transitional care
    - Referral to community and social support services
    - Other new services
        - Accompany participants to critical appointments
        - Provider housing navigation services for members experiencing homelessness
        - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
        - Trauma informed care

❖ **PHM Activities and Resources [PHM 1A Factor 3]**

➢ CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations.

➢ As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes.

❖ **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**

➢ CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members

are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.

- CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
- CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
- CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

❖ **Delivery System for Practitioner/Provider Support [PHM3 A]**

- **Information Sharing**
  - CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actionable data.
- **Practice Transformation Technical Assistance (New Idea)**
  - One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.
- **Provider Coaching and Leadership Development (New Idea)**
  - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
  - Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.
- **Pay for Value [PHM3 B]**
  - CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

❖ **Population Health Management Impact [PMH 6]**

- **Measuring Effectiveness**
  - CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience.

CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary team through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.

- **Improvement and Action**

- Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains as define in the CalOptima Quality Improvement Program.

***APPENDICES**:*

2018 NCQA PHM Standards

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Overview

Notable Changes for 2018

Changes to the Policies and Procedures

- ***Section 1***
  - Clarified that a Medicaid-only organization that manages CHIP members included those members in its Medicaid product line.
  - Described how to navigate NCQA's web-based application process.
  - Clarified, under "Organization Obligations," that a Discretionary Survey is based on the standards in effect during the discretionary survey.
- ***Section 2***
  - Added reference to government requirements under "State and Federal Agency Surveys."
  - Added URL for NCQA Guidelines for Advertising and Marketing (http://www.ncqa.org/marketing.aspx) under "Marketing accreditation results"
  - Added PHM 1, Element A to the list of elements with critical factors.
- ***Section 3:***
  - Added "Web-based survey platform" subhead and text.
  - Replaced QI 5 with PHM 4 under "File review results."
- ***Section 4***

  Added a note about Federal Medicaid Rule: §438.332 regarding state deeming survey results.
- ***Section 5***
  - Updated English-speaking USA and Canada fraud hotline number to 844-440-0077.
  - Updated language under "Notifying NCQA of Reportable Events" subhead and added "Annual Attestation of Compliance With Reportable Events" and "NCQA Investigation" subheads and text.
  - Updated language under "Mergers and Acquisitions and Changes to Operations" subhead.
- ***Section 6***
  - Described how to navigate NCQA's Web-based application process.

Changes to the standards and guidelines

- New category, Population Health Management (PHM):
  - *PHM 1: PHM Strategy.*
  - *PHM 2: Population Identification.*
  - *PHM 3: Delivery System Supports.*
  - *PHM 4: Wellness and Prevention.*
  - *PHM 5: Complex Case Management.*
  - *PHM 6: Population Health Management Impact.*
- Moved the following standards to the PHM category:
  - *QI 5: Complex Case Management (PHM 5).*
  - *MEM 1: Health Appraisals (PHM 4,* Elements A–G).
  - *MEM 2: Self-Management Tools (PHM 4,* Elements H–K).

- Eliminated the following standards and elements:
  - *QI 5:*
    - Element B: Complex Case Management Program Description.
    - Element C: Identifying Members for Case Management.
    - Element J: Measuring Effectiveness.
  - *QI 6: Disease Management.*
  - *QI 7: Practice Guidelines.*
  - *MEM 7: Support for Healthy Living.*
  - *UM 4,* Element H: Appropriate Classification of Denials.
- Added a factor to NET 3, Element A: Assessment of Member Experience Accessing the Network.
- Renumbered the QI and MEM standards to account for standards and elements that were incorporated into the PHM category or eliminated.

Changes to the appendices

- ***Appendix 1***
  - Updated points for all evaluation options to account for new PHM category and eliminated QI standards, UM 4, Element H and MEM standards.
- ***Appendix 2***
  - Added new measures for the commercial, Medicare and Medicaid product lines. Refer to the table below.

Measure		Commercial	Medicare	Medicaid
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	✓
IET	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment—*Initiation of AOD Treatment rate*	✓	✓	✓
PSA	Non-Recommended PSA-Based Screening in Older Men	NA	✓	NA
EDU	Emergency Department Utilization	✓	✓	NA
SPC	Statin Therapy for Patients With Cardiovascular Disease—*Both rates*	✓	✓	✓
SPD	Statin Therapy for Patients With Diabetes—*Both rates*	✓	✓	✓
IMA	Immunizations for Adolescents (Combination 2)	✓	NA	✓

  - Retired the measures listed in the table below.

Measure		Commercial	Medicare	Medicaid
ABA	Adult BMI Assessment	Retain	✓	Retain
CDC	Comprehensive Diabetes Care—*Medical Attention for Nephropathy rate*	✓	✓	✓
	Comprehensive Diabetes Care—*HbA1c Poor Control (>9%) rate*	✓	✓	✓
MSC	Medical Assistance With Smoking and Tobacco Use Cessation —*Advising Smokers to Quit rate*	✓	Retain	Retain
IMA	Immunizations for Adolescents (Combination 1)	✓	NA	✓

- ***Appendix 3***
  - Updated points reporting category based on changes in appendix 1.

- ***Appendix 4***
  - Updated calculation of HEDIS score based on changes in appendix 2
- ***Appendix 5***
  - Updated standards and elements eligible for automatic credit based on the new PHM category and eliminated QI requirements. (Refer to *Appendix 5* for the list of changes.)

Accreditation: A Symbol of Quality and Improvement

Why NCQA?

Health plans accredited by NCQA demonstrate their commitment to delivering high-quality care through one of the most comprehensive evaluations in the industry, and the only assessment that bases results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). NCQA publicly reports quality results, allowing "apples-to-apples" comparison among plans. NCQA's Health Plan Accreditation program helps organizations demonstrate their commitment to quality and accountability.

Health plans choose NCQA Health Plan Accreditation because:

- **Employers want it.** Many employers—especially the Fortune 500 employers—do business only with NCQA-Accredited plans. They and other purchasers want to keep employees healthy and productive and maximize the value of their health investment by focusing on quality care. The National Business Coalition on Health's widely used eValue8 tool captures NCQA Accreditation status and HEDIS/CAHPS scores as an important indicator of a plan's ability to improve health, and health care.
- **It meets regulatory requirements.** NCQA Accreditation contains many of the key elements that federal law and regulations require for State Health Insurance and Marketplace plans. Forty-two states recognize NCQA Accreditation as meeting their requirements for Medicaid or commercial plans; 17 states mandate it for Medicaid. The Federal Employees Health Benefit Program accepts NCQA Accreditation.
- **Consumers are looking for quality.** As consumers become more responsible for managing their health care, consumer interest in choosing high-quality plans will grow. The standards focus on key patient protections that consumers, regulators, public purchasers and employers value.
- **It's flexible and comprehensive.** NCQA builds flexible, yet rigorous standards that apply to all types of health plans. Annual updates to accreditation standards support the fast-changing needs of regulators and the health care marketplace. NCQA's Health Plan Accreditation is the most widely recognized accreditation program in the United States.

The rigor and competitive pricing of NCQA's program represent an excellent value for health plans. NCQA supports the accreditation process through its publications, users' groups and educational programs, making the path to performance-based accreditation accessible and feasible.

Changes and Updates: *What's New in 2018?*

NCQA continuously assesses the health care landscape, as well as new and pending regulations, to enhance accreditation standards on an annual basis. The HPA 2018 focuses on a new category*:* Population Health Management (PHM).

New PHM Category: NCQA combined existing population health management related requirements from Health Plan Accreditation categories (Quality Management and Improvement [QI] and Member Connections [MEM]) and new requirements that reflect a broader, population-wide focus on care management. The update removes elements that no longer add value.

- ***Reasons for the update:*** NCQA's goal is to streamline evaluation of an organization's population health management strategy by consolidating PHM-related elements into one category. The new category provides flexibility in how plans manage their members and encourages health plans to work with the delivery system to deliver quality care.

Tracking Out-of-Network Requests: A new factor (3) in NET 3A: Assessment of Member Experience Accessing the Network expands tracking of out-of-network requests for services to all product lines.

- ***Reasons for the update:*** Network adequacy is an important area of concern for consumers and purchasers alike because it affects timely access to care and out-of-pocket costs among other areas. The intent of this requirement is that organizations monitor and identify issues of access to primary care services, behavioral healthcare services and other specialty services. Analysis of out-of-network data helps organizations understand why members seek out-of-network services. Finding ways to address these occurrences can lead to better member experience.

Marketplace Readiness

NCQA's Health Plan Accreditation is the superior choice for insurers offering Marketplace products. It provides a "glide path" to accreditation; plans with varied goals and capabilities can earn the NCQA seal. The glide path involves three options or steps:

1. **Interim Evaluation** is for organizations that need accreditation before or soon after they open for business. It focuses on insurers' policies and procedures, does not include HEDIS/CAHPS reporting.
2. **First Evaluation** is for organizations new to NCQA. HEDIS/CAHPS reporting is required only in the final year, helping plans prepare for their Renewal Evaluation.
3. **Renewal Evaluation** is available to NCQA-Accredited organizations seeking to extend their accreditation. HEDIS/CAHPS reporting is mandatory, and performance results count in the scoring.

Accreditation Scoring System

NCQA uses the standards and audited HEDIS/CAHPS results to evaluate an organization. Depending on the Evaluation Option selected, a total of 50 or 100 points is possible (i.e., performance against the standards accounts for 50 possible points; HEDIS results account for 50 possible points).

Organizations submit audited results for designated HEDIS measures for each product line/product brought forward for accreditation as required for the Evaluation Option selected. To ensure validity, accuracy and comparability, an NCQA-Certified HEDIS Compliance Auditor must audit the results. NCQA evaluates the organization's audited HEDIS results against established benchmarks and thresholds to determine the score.

Accreditation Status Levels

Because most organizations offer several product lines (i.e., commercial, Marketplace, Medicare, Medicaid), NCQA determines accreditation status by product line for HMO, POS PPO and EPO products. Each product line/product reviewed by NCQA earns one of the following accreditation status levels, based on evaluation of the organization's performance against the standards and HEDIS results (if applicable) and the Evaluation Option.

- Excellent.
- Commendable.
- Accredited.
- Provisional.
- Interim.
- Denied.

New: PHM Category of Standards

Health care expenditures account for 17 percent of the gross domestic product ($17 trillion) in the United States, estimated to be 20 percent by 2020.[3] Although health spending is the highest in the world, our life expectancy is significantly shorter than that of other industrialized nations. Guided by the Institute for Healthcare Improvement's (IHI) Triple Aim framework,[4] the federal government, states, health plans and other stakeholders are tackling these challenges through various initiatives. The Triple Aim framework has three main objectives: improve patient experience of care, improve the health of populations and reduce the per capita cost of health care.

NCQA emphasizes the Triple Aim throughout Health Plan Accreditation through its new standard category, Population Health Management (PHM). PHM addresses health at all points on the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.[5]

This category's scope facilitates population health management, not public health—an important distinction. "Public health" is a broad term for the coordinated efforts of local, state and national health departments to improve the quality of health for insured and uninsured community members. "Population health management" supports care activities for a defined population.

The PHM standards establish basic expectations:

1. Organizations have a population health management strategy that focuses on the "whole person" and the member's entire care journey.
2. Organizations can provide wellness services (e.g., health appraisal administration, self-management tools) and intervene with highest-risk members (i.e., requiring complex case management).
3. Organizations have the flexibility to choose members/populations with which to intervene (including the specific population under complex case management).
4. Organizations are committed to supporting their delivery system to facilitate better health outcomes and encourage value-based decisions.

The PHM requirements were developed through literature reviews, Stakeholder Advisory Committee discussions, feedback from our public comment period and enhanced feedback from additional stakeholder advisory councils and groups.

Delivery System Support and Value-Based Payment Arrangements

NCQA recognizes the need to align organizations with the delivery system, including hospitals, accountable care entities, practitioners and PCMHs, and other vendors delivering care. Toward that end, NCQA recommends standards for delivery system supports, with elements that allow flexibility in how organizations support delivery system. The elements provide many methods to support providers and allow the health plans to determine which best fit their network arrangement and current delivery system capabilities. Through these requirements, NCQA intends to increase data sharing and transparency between plans and providers. Also, NCQA requires a report describing the organization's value-based payment arrangements to better understand the changing landscape of the healthcare market *(PHM 3: Delivery System Supports)*.

[3]CMS Strategy: The Road Forward 2013-2017. https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf
[4]IMI Triple Aim Initiative. http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx
[5]Population Health Alliance. http://www.populationhealthalliance.org/research/understanding-population-health.html

Eliminated Elements

NCQA eliminated the following standards and elements. With these changes, the HPA focus shifts from single-condition evaluation to population health-based evaluation. Retired elements include:

- ***QI 5:***
  - Element B: Complex Case Management Program Description.
  - Element C: Identifying Members for Case Management.
  - Element J: Measuring Effectiveness.
  - Element K: Action and Remeasurement.
- ***QI 6:***
  - Element A: Program Content.
  - Element B: Identifying Members for DM Programs.
  - Element C: Frequency of Member Identification.
  - Element E: Interventions Based on Assessment.
  - Element F: Eligible Member Active Participation.
  - Element G: Informing and Educating Practitioners.
  - Element H: Integrating Member Information.
  - Element I: Experience With Disease Management.
  - Element J: Measuring Effectiveness.
- ***QI 7:***
  - Element A: Adoption of Guidelines.
  - Element B: Adoption of Preventive Health Guidelines.
  - Element C: Relation to DM Programs.
  - Element D: Performance Measurement.
- ***MEM 7:***
  - Element A: Identifying Members.
  - Element B: Targeted Follow-Up With Members.

Where to Find Specific Information

The *Standards and Guidelines* include policies and procedures, standards and elements, scoring guidelines and appendices.

Policies and Procedures

- Information on organizations eligible for accreditation.
- Responsibilities of organizations seeking accreditation.
- Information on applying for accreditation.
- Information on the survey tool and readiness evaluation.
- Information on reporting accreditation results.
- Information on annual reevaluation.
- Information on the Accreditation Survey process.
- Information on evaluating HEDIS results and calculating HEDIS scores.
- Information on the Reconsideration process.

Accreditation Standards, Organized by Category

- The standards, elements and factors.
- A summary of changes from the previous standards year.
- Scoring guidelines describing requirements for each standard, element and factor.
- Information about how an organization can demonstrate performance against the element's requirements.
- Data sources for demonstrating compliance with requirements.
- The scope of review.
- The look-back period.

Appendices

- Appendix 1: Standard and Element Points for 2018.
- Appendix 2: HEDIS and CAHPS Points for HEDIS Reporting Year 2018.
- Appendix 3: Points by Reporting Category for 2018.
- Appendix 4: Calculating the Total HEDIS Score.
- Appendix 5: Delegation and Automatic Credit Guidelines.
- Appendix 6: CMS Regions.
- Appendix 7: Merger, Acquisition and Consolidation Policy for Health Plan Accreditation and LTSS Distinction.
- Appendix 8: Answers to Commonly Asked Questions.
- Appendix 9: Glossary.
- Appendix 10: Summary of Changes for 2018.

Other Important NCQA Information

NCQA publications, user groups and educational programs facilitate the evaluation process. They help plans succeed by making the path to performance-based accreditation accessible and feasible. In addition to the web-based survey platform, NCQA provides a variety of information to help organizations prepare for Accreditation Surveys.

- NCQA produces many publications relevant to organizations. Call NCQA Customer Support at 888-275-7585 or go to the NCQA website (www.ncqa.org).
- Access policy clarifications from the NCQA Policy Clarification Support (PCS) system on the NCQA Web page (http://my.ncqa.org). General questions are usually answered within 2 business days; complex questions are usually answered within 30 days.
- Find corrections, clarifications and policy changes to this publication at http://www.ncqa.org/tabid/119/Default.aspx/
- Find frequently asked questions (FAQ) at http://ncqa.force.com/faq/FAQSearch FAQs are updated on the 15th of the month or on the first business day following the 15th of the month.
- Organizations that are involved in NCQA Accreditation and Certification activities are encouraged to join the Accreditation and Certification Users Group (ACUG). The ACUG provides a learning and development platform for members to discuss updates applicable to their organization's procedures. Membership benefits include a monthly newsletter; WebEx discussions; and vouchers for publications, educational conferences and Quality Compass. For more information, e-mail acug@ncqa.org or go to http://www.ncqa.org/programs/accreditation/accreditation-certification-users-group-acug for a full description of the program.

- Organizations collecting HEDIS data are encouraged to join the NCQA HEDIS Users Group (HUG) for technical assistance and guidance on interpreting measure specifications. Membership benefits include NCQA HEDIS and accreditation publications, newsletters, Internet seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information. For more information, e-mail hug@ncqa.org.
- NCQA educational seminars provide valuable information on NCQA standards, the survey process and HEDIS. Course offerings range from a basic introduction to NCQA standards and HEDIS measures to advanced techniques for quality improvement. Visit the NCQA website or call NCQA Customer Support at 888-275-7585.
- NCQA staff are available to help organizations determine the Evaluation Option for which they are eligible. Staff provide step-by-step guidance on the application process, which includes an overview of policies and procedures, the fee structure, timelines and survey preparation. Contact ApplicationsandScheduling@ncqa.org.

Other NCQA Programs

NCQA offers the following accreditation programs:

- Accountable Care Organization (ACO).
- Case Management (CM).
- Case Management for Long-Term Services and Supports Programs (CM-LTSS).
- Disease Management (DM).
- Managed Behavioral Healthcare Organization (MBHO).
- Wellness and Health Promotion (WHP).

NCQA offers the following certification programs:

- Accreditation in Utilization Management, Credentialing and Provider Network UM/CR/PN).
- Credentials Verification Organization (CVO).
- Disease Management (DM).
- Health Information Products (HIP).
- Physician and Hospital Quality (PHQ).
- Wellness and Health Promotion (WHP).

NCQA offers the following recognition programs:

- Diabetes Recognition (DRP).
- Heart/Stroke Recognition (HSRP).
- Patient-Centered Connected Care™
- Patient-Centered Medical Home (PCMH).
- Patient-Centered Specialty Practice (PCSP).
- Oncology Medical Home (PCMH-O).
- School-Based Medical Home (SBMH).

NCQA offers the following evaluation program:

- New York Ratings Examiner Reviews (NYRx).

NCQA offers the following distinction programs:

- Multicultural Health Care (MHC).
- Long-Term Services and Supports (LTSS).

NCQA offers the following distinction programs for recognized PCMHs:

- Patient Experience Reporting.
- Behavioral Health Integration.
- Electronic Quality Measures (eCQM) Reporting.

Note: *Organizations that contract with NCQA-Accredited or NCQA-Certified organizations can reduce their delegation oversight. Refer to* Appendix 5: Delegation and Automatic Credit Guidelines.

11/20/17: Add the following as the last bullet under "NCQA offers the following accreditation programs":
• Utilization Management, Credentialing and Provider Network (UM-CR-PN).
• Delete the first bullet under "NCQA offers the following certification programs" that reads:
• Accreditation in Utilization Management, Credentialing and Provider Network (UM-CR-PN).

Population Health Management

Back to Agenda

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Additions

- Added *PHM 1, Element A: Strategy Description* as a new element.

Clarifications

- Added "interactive contact" to the element stem (Element B).
- Updated the scope of review to state that NCQA reviews up to 4 randomly selected programs (Element B).
- Added language to address how the element will be reviewed for the 2019 Standards Year (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **Activities that are not direct member interventions.**
4. **How member programs are coordinated.**
5. **How members are informed about available PHM programs.**

Critical factors: Score cannot exceed 20% if critical factors are not met.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a description of the organization's comprehensive PHM strategy. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

Factor 1 is a **critical factor** that the organization must meet to score higher than 20% on this element.

The organization has a comprehensive strategy for population health management that *at minimum* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

***Factors 1, 2:* Four areas of focus**

At a minimum, the description includes for each of the four areas of focus:

- Goals (factor 1).
- Populations targeted (factor 1).
- Program or services for each area of focus (factor 2).

Goals are measurable and connected to a targeted population. NCQA does not prescribe a definition of "program or services." Programs and services may be provided to members by the organization or by other entities.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities conducted by the organization that support PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across potential settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its methods for informing members about all available PHM programs and services. Programs and services include any level of contact. The organization may make the information available on its website; by mail, e-mail, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the targeted population report receiving annual influenza vaccinations.
  - Targeted populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.

  - Programs or services: Community flu clinics, e-mail and mail reminders, radio and TV advertisement reminding public to receive vaccine.
- Goal: 10 percent of targeted population reports meeting self-determined weight-loss goal.
  - Targeted population: Members with BMI 27 or above enrolled in wellness program.
  - Programs or services: Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Targeted population:
    - Members discovered at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - Programs or services: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - Targeted population: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - Programs or services: Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - Targeted population: Members who are prescribed high-alert medications and receive home health care.
  - Activity: Collaborate with community-based organizations to complete medication reconciliation during home visits.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of three days or more by 2 percentage points compared to baseline.
  - Targeted population: Members admitted through the emergency department who remain in the hospital for three days or more.
  - Program or services: Organization-based case manager conducts follow-up interview post-stay to coordinate needed care.
  - Activity: Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - Targeted population: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - Programs or services: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - Targeted population: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - Programs or services: Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**

- Data and information sharing with practitioners.
- Interactions and integration with delivery systems (e.g., contracting with accountable care organizations).
- Providing technology support to or integrating with patient-centered medical homes.

- Integrating with community resources.
- Value-based payment arrangements.
- Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborating with hospitals to improve patient safety.

Element B: Informing Members——*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. **How members become eligible to participate.**
2. **How to use program services.**
3. **How to opt in or opt out of the program.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: For surveys beginning on or after July 1, 2019, NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: 6 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure e-mail.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or e-mail, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, e-mail, telephone, mobile device or Internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234.

If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Additions

- Added *PHM 2, Element A: Data Integration* as a new element.
- Added *PHM 2, Element D: Segmentation* as a new element.
- Split factor 1 into two factors, factors 1 and 2, updated scoring and added social determinants of health to factor 1 language (Element B).
- Added a new factor 3: "Review community resources for integration into program offerings to address member needs" (Element C).

Clarifications

- Updated the scope of review for First Surveys and Renewal Surveys to state "at least once during the prior year" (Element B).
- Updated the explanation to reflect population health management (Elements B, C).
- Updated the look-back period for all surveys to state "prior to the survey date" (Element C).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. **Medical and behavioral claims or encounters.**
2. **Pharmacy claims.**
3. **Laboratory results.**
4. **Health appraisal results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim, First and Renewal Surveys: Prior to the survey date.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results would not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources are those that aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges or other community collaboratives. The organization must have access to use data from the source to meet the intent.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
  - Health information line.

Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to**:**

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

The organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, social determinants of health must be assessed. **Social determinants of health**[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: **Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

Factor 3: **Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

Factors 4, 5: **Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for Medicare.

Examples

Factors 1, 2: **Relevant characteristics**

Social determinants of health include:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, and benches).
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Race/ethnicity and language preference.

Element C: Activities and Resources——*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period *For Interim Surveys, First Surveys, and Renewal Surveys:* Prior to the survey date.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's reports demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of

targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high risk pregnancy, multiple inpatient admissions). Organizations may use various risk stratification methods or approaches to determine actionable subsets.

Segmentation and stratification methods use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs/services members are eligible for. Methods may also include utilization/resource use or cost information, but methods that use only cost information to determine categories do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may not add to 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management. Reports must reflect the number of members eligible for each PHM program.

Examples

***Health Plan A:* Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

***Health Plan A:* Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
No risk factors	Routine member newsletters	6,000	15%
No associated data	None	4,800	12%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Additions

- Added *PHM 3: Delivery System Supports* as a new standard.

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. **Sharing data.**
2. **Offering certified shared-decision making aids.**
3. **Providing practice transformation support to primary care practitioners.**
4. **Providing comparative quality information on selected specialties.**
5. **Providing comparative pricing information for selected services.**
6. **One additional activity to support practitioners or providers in achieving PHM goals.**

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For *Interim Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and *Renewal Surveys*: 6 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers with which they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Certified shared-decision making aids.**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

The organization provides information (e.g., through the organization, practitioner, provider) about how, when, what conditions, and to whom certified SDM aids are offered. SDM aids must be certified by a third-party entity that evaluates quality. At least one SDM aid must be certified to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization can receive automatic credit for factors 3 and 6 if the organization is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent clinics or other care providers.
- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
- Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 3

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
  - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
    - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization demonstrates it has VBP arrangement(s) by reporting the percentage of payment tied to VBP	No scoring option	No scoring option	No scoring option	The organization does not demonstrate that it has VBP arrangement(s)

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and *Renewal Surveys*: Prior to the survey date.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The FFS model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS* Reports *to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- **Pay-for-performance (P4P):** Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared savings:** Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- **Shared risk:** Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- **Two-sided risk sharing:** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based payment:** Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- (Numerator:) Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- (Denominator:) Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples

None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Additions

- Added factor 14 (Safety behaviors), added explanation text and updated the 100% scoring to reflect the new factor (Element C).

Clarifications

- Revised standard stem and intent statement.
- Added an exception for the Medicaid product line (Elements A–G).
- Clarified the explanation under the subhead for *Factor 5: Special needs assessment* to state that questions include specific demographics to meet the requirement (Element A).
- Clarified the explanation under the subhead for factor 2 to include requirements for the HA disclosure (Element B).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

Factor 2: **Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: **Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: **Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: **Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. **An overall summary of the participant's risk or wellness profile.**
2. **A clinical summary report describing individual risk factors.**
3. **Information on how to reduce risk by changing specific health behaviors.**
4. **Reference information that can help the participant understand the HA results.**
5. **A comparison to the individual's previous results, if applicable.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot

provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

***Factor 2:* Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

***Factor 3:* Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

***Factor 4:* Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

***Factor 5:* Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA, and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy to understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys, NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. **Language is easy to understand.**
2. **Members' special needs, including vision and hearing, are addressed.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs and the organization assesses its tools for members who have vision or hearing limitations. All must be addressed in order to receive credit for this factor.

Exception

Factors marked "No" in Element A are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For Renewal Surveys, NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element A are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each required seven health areas:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Additions

- Combined former factor 1 (Health information line referral), factor 2 (DM program referral), factor 4 (UM referral) to the new factor 1 (Medical management program referral), updated scoring and added Explanation text for that factor (Element A).

Clarifications

- Clarified the standard statement to specify that highest-risk members are included in the CCM program.
- Replaced “psychosocial issues” with “social determinants of health” in factor 5 and revised the explanation text for that factor (Element C).
- Clarified the scope of review to state “files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management” (Elements D, E).
- Updated the factor 5 language to state “initial assessment of social determinants of health” and revised the explanation text (Element D).
- Updated timeliness of assessment to state that the organization's initial assessment begins within 30 calendar days of identification and is completed within 60 days of identification (Element D).
- Added a fourth bullet under the subhead *Timeliness of assessment:* “The member is dead” (Element D).
- Added an example: *Factors 1–5: Case Management—Ongoing Management* (Element E).
- Added a bullet under the subhead for *Factor 1: Analyzing member feedback* in the explanation (Element F).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. **Medical management program referral.**
2. **Discharge planner referral.**
3. **Member or caregiver referral.**
4. **Practitioner referral.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

***Factor 3:* Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples

None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of members' health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.**

15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This is a **structural requirement.** The organization must present its own documentation.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Factor 1: **Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment should includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

Factor 2: **Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

Factor 3: **Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to activities of daily living, such as eating, bathing and mobility.

Factor 4: **Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If a member does not have expressed life-planning instructions on record, during the first contact the case manager determines if life-planning instructions are appropriate. If they are not, the case manager records the reason in the member's file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It should include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 11:* Evaluation of community resources**

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.

***Factor 12:* Individual case management plan and goals**

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frame for reevaluation of goals.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.
  - Time frames for reevaluation are specified in the case management plan.

***Factor 13:* Identification of barriers**

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

***Factor 14:* Referrals to available resources**

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

***Factor 15:* Follow-up schedule**

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.

- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 14:* Assessment of barriers[2]**

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
  - Self-administer medication (e.g., oral, inhaled or injectable).
  - Self-administer medical procedures/treatments (e.g., change wound dressing).
  - Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
  - Maintain a prescribed diet.
  - Chart daily weight, blood sugar.

[2]Lorig, K. 2001. *Patient Education, A Practical Approach.* Sage Publications, Thousand Oaks, CA. 186–92.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. NCQA scores each factor "No" for files of initial assessments completed 60 calendar days or more from member identification, unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, e-mail or fax.
- Natural disaster.
- The member is dead.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Files excluded from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: **Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

Factor 3: **Initial assessment of activities of daily living**

The file or case record documents a case manager's assessment of the member's functional status relative to at least the six basic ADLs. Bathing, hygiene, dressing, toileting, transferring or functional mobility and eating.

Factor 4: **Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Factor 6: **Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.
- Health literacy.

Factor 7: **Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: **Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. The documentation describes what resources are in place, whether these a sufficient for the members needs and notes specific gaps that should be addressed.

Factor 9: **Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of member's specific health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: **Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources. At a minimum, the evaluation includes:

- Community mental health.
- Transportation.
- Wellness programs.
- Nutritional support.
- Palliative care programs.

If a specific resource is not applicable to the member's situation, the case record or file documents why.

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

During the first contact, the case manager assesses and documents whether it is appropriate to discuss these activities and documents with the member. If determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place.

If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples

None.

Element E: Case Management—Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.

- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:*** **Case Management—Ongoing Management**

Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/2017	**Initial Assessment Completed:** 1/30/2017
Goal 1:	Secure stable housing for member by 2/11/2017. **(Factor 1**)
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. **(Factor 1)** *Strategies to achieve goal:* Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services. *Barriers to goal:* Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. **(Factor 2)** *Progress assessment:* Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2017 and investigated group housing. **(Factor 5)**	
Goal 1 completed:	2/16/2017. ***Note:*** *Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings.* **(Factor 5)**
Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2017) over 3–6 months. • Improve 5 points from baseline by 4/30/2017. • Improve 11 points from baseline by 7/30/2017. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2017. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2017. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2017. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**

Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via [number]. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*: *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* (Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. **Obtaining feedback from members.**
2. **Analyzing member complaints.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys,* NCQA reviews the organization's most recent annual data collection and evaluation report.

For *Renewal Surveys,* NCQA reviews the last two annual data collections and evaluation reports.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…	Very Satisfied		Satisfied		Combined		Sample Size	Percentage of Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan?	75	60	25	20	100	80	125	No
With how the case manager helped you get the care you needed?	80	64	35	28	115	92	125	Yes
With the case manager's attention and help with problems?	70	56	45	36	1151	92	125	Yes
With how the case manager treated you?	85	68	35	28	120	96	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2017	Total 2016
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2018; there were 26 in 2017. Totals by category were also lower in 2018 than in 2017. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact *—Refer to Appendix 1 for points*

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Additions

- Added *PHM 6: Population Health Management Impact* as a new standard.

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. **Quantitative results for relevant clinical, cost/utilization and experience measures.**
2. **Comparison of results with a benchmark or goal.**
3. **Interpretation of results.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. Beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

The organization conducts an annual quantitative analysis of findings.

***Factor 1:* Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. There are two types of clinical measures:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality).
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization uses complex case management member experience results and member experience results from one other program or service.

CAHPS and other general survey questions do not meet the intent of this element.

***Factor 2:* Comparison of results**

The organization performs a first-level, quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Interpretation of results gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The measures must be analyzed and assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. The interpretation of the results should include interpretation of the measures and should go beyond just a presentation of the quantitative results of the measures. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36y to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. **Identify opportunities for improvement.**
2. **Act on one opportunity for improvement.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, for surveys beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: Prior to the survey date.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

***Factor 1:* Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

***Factor 2:* Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

This element is NA for 2018.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Additions

- Added *PHM 7: Delegation of PHM* as a new standard.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element B: Provision of Member Data to the Delegate—*Refer to Appendix 1 for points*

The organization provides the following information to its delegates when requested:

1. **Member experience data, if applicable.**
2. **Clinical performance data.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a sample of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. NCQA reviews the organization's process for sharing information with its delegates.

For First Surveys and Renewal Surveys, NCQA also reviews evidence that the organization provides the delegate with direct access to or shared the information with its delegates when requested throughout the look-back period.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

If the organization delegates PHM activities, it allows the delegate to collect performance data necessary to assess member experience and clinical performance, as applicable. If the organization does not allow the delegate to collect data from members or practitioners directly, it provides data to the delegate to assess its performance.

NCQA scores this element "Yes" if the organization allows the delegate to collect performance data directly or provides data to the delegate.

***Factor 1:* Member experience data**

The organization provides data from complaints, CAHPS 5.0H survey results and other data collected on members' experience with the delegate's services.

***Factor 2:* Clinical performance data**

The organization provides data to the delegate on HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or provide results of relevant clinical performance measures.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element C: Provisions for PHI—*Refer to Appendix 1 for points*

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. **A list of the allowed uses of PHI.**
2. **A description of delegate safeguards to protect the information from inappropriate use or further disclosure.**
3. **A stipulation that the delegate ensures that subdelegates have similar safeguards.**
4. **A stipulation that the delegate provides individuals with access to their PHI.**
5. **A stipulation that the delegate informs the organization if inappropriate use of the information occurs.**
6. **A stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

***Factor 1:* Allowed uses of PHI**

The delegation agreement specifies PHI the delegate may use and disclose, and to whom PHI may be disclosed.

***Factors 2, 3:* Delegate and subdelegate safeguards**

The organization provides reasonable administrative, technical and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

***Factor 4:* Access to PHI**

No additional explanation required.

Factor 5: **Inappropriate use of PHI**

The agreement specifies procedures for delegates to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.

Factor 6: **Disposal of PHI**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements do not involve the use, creation or disclosure of PHI in any form.
- The agreement states that the delegation arrangement does not involve PHI.
- Delegation arrangements are with covered entities.

Examples None.

Element D: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For *Renewal Surveys*: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within the prescribed look-back periods prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the prescribed look-back period, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities less than 6 months or 12 months, as prescribed by the look-back period, prior to the survey date, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide, predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element E: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For *Interim Surveys*, NCQA reviews the organization's review of the delegate's PHM program.

For *First Surveys*, NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 6 months for all other PHM activities.

For *Renewal Surveys*: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

***Factor 2:* Annual file audit**

If the organization delegates complex case management , it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

***Factor 3:* Annual evaluation**

No additional explanation required.

***Factor 4:* Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Examples

None.

Element F: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For *First Surveys*, NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Population Health Management

Back to Agenda

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the Explanation text regarding the four areas of focus to the subsection *Factors 1, 2: Four areas of focus* to clarify that the language applies to factors 1 and 2 (Element A).
- Added an example regarding clinical safety to the subhead *Patient safety* in the examples for factors 1,2 (Element A).
- Added "materials" as a data source and revised the scope of review to remove the reference to July 1, 2019 (Element B).
- Revised the look-back period for Renewal Surveys to 6 months for materials and 12 months for documented process (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. Goals and populations targeted for each of the four areas of focus.*

2. Programs or services offered to members.

3. Activities that are not direct member interventions.

4. How member programs are coordinated.

5. How members are informed about available PHM programs.

***Critical factors: Score cannot exceed 20% if critical factors are not met.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1 is a critical factor that the organization must meet to score higher than 20% on this element.

***Factors 1, 2:* Four areas of focus**

The organization has a comprehensive strategy for population health management that, *at a minimum,* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

At a minimum, the description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable and specific to a target population. A program is a collection of services or activities to manage member health. A service is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities it conducts in support of PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its process for informing members about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the target population report receiving annual influenza vaccinations.
  - Target populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.
  - *Programs or services:* Community flu clinics, email and mail reminders, radio and TV advertisement reminding the public to get vaccinated.
- Goal:10 percent of the target population reports meeting a self-determined weight-loss goal.
  - *Target population:* Members with BMI 27 or above enrolled in wellness program.
  - *Programs or services:* Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Target population:
    - Members discovered to be at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - *Programs or services:* Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - *Target population:* Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - *Programs or services:* Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - *Target population:* Members who are prescribed high-alert medications and receive home health care.
  - *Activity:* Collaborate with community-based organizations to complete medication reconciliation during home visits.
- Goal: Improve clinical safety.
  - *Target population:* Members receiving in-patient surgical procedures.
  - *Activity:* Distribute information to members that facilitates informed decisions regarding care such as:
    - Questions to ask surgeons before surgery.
    - Questions to ask the practitioner about medication interactions.
    - Resources needed at discharge such as appropriate nutrition or transportation assistance.
  - *Activity:* Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of 3 days or more by 2 percentage points compared to baseline.
  - *Target population:* Members admitted through the emergency department who remain in the hospital for three days or more.
  - *Program or services:* Organization-based case manager conducts a follow-up interview post-stay to coordinate needed care.
  - *Activity:* Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - *Target population:* Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - *Programs or services:* Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - *Target population:* Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - *Programs or services:* Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**

- Share data and information with practitioners.
- Interactions and integration with delivery systems (e.g., contract with accountable care organizations).
- Provide technology support to or integrate with patient-centered medical homes.
- Integrate with community resources.
- Value-based payment arrangements.
- Collaborate with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborate with hospitals to improve patient safety.

Element B: Informing Members—*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.

2. How to use program services.

3. How to opt in or opt out of the program.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 6 months for materials; 12 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care.

To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Clarifications

- Revised the look-back period for First Surveys to 6 months and for Renewal Surveys to 12 months (Element A).
- Revised the first sentence of the Explanation for *Factor 1: Characteristics and needs* to state, "To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population" (Element B).
- Revised the look-back period for First and Renewal Surveys to state "at least once during the prior year" (Element C).
- Clarified the scope of review to state that NCQA reviews the most recent report for First Surveys and Renewal Surveys (Element D).
- Clarified the Explanation text under the subhead *Reports* to state that data may total more than 100 percent (Element D).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.

2. Pharmacy claims.

3. Laboratory results.

4. Health appraisal results.

5. Electronic health records.

6. Health services programs within the organization.

7. Advanced data sources.

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results do not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor.

Exceptions

None.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
- Health information line.

Advanced data sources may require two-way data transfer. The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to:

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, the organization assesses social determinants of health. Social determinants of health[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

***Factor 2:* Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

***Factor 3:* Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

***Factors 4, 5:* Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for the Medicare product line.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Examples

***Factors 1, 2:* Relevant characteristics**

- Social determinants of health include:
  - Resources to meet daily needs.
  - Safe housing.
  - Local food markets.
  - Access to educational, economic and job opportunities.
  - Access to health care services.
  - Quality of education and job training.
  - Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
  - Transportation options.
  - Public safety.
  - Social support.
  - Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
  - Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
  - Socioeconomic conditions.
  - Residential segregation.
  - Language/literacy.
  - Access to mass media and emerging technologies.
  - Culture.
- Physical determinants include:
  - Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
  - Built environment, such as buildings, sidewalks, bike lanes and roads.
  - Worksites, schools and recreational settings.
  - Housing and community design.
  - Exposure to toxic substances and other physical hazards.
  - Physical barriers, especially for people with disabilities.
  - Aesthetic elements (e.g., good lighting, trees, benches).
  - Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
  - Nature and extent of carved out benefits.
  - Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
  - Race/ethnicity and language preference.

Element C: Activities and Resources—*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.

- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's most recent report demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.
For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high-risk pregnancy, multiple inpatient admissions). The organization may use more than one risk stratification methods to determine actionable subsets.

Segmentation and stratification use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs or services for which members are eligible. Although these methods may include utilization/resource use or cost information. Methods that use only cost information for segmentation and stratification do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Examples

Health Plan A: **Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: **Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
BMI over 30	Weight management program	4,800	12%
No risk factors	Routine member newsletters	12,000	30%
No associated data	None	8,000	20%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the examples for *Factor 3: Providing practice transformation support to primary care practitioners* as the third paragraph under *Related information* (Element A).
- Revised the scoring language for 100% and 0% (Element B).
- Revised the look-back period for First Surveys to 6 months and Renewal Surveys to 12 months (Element B).

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.

2. Offering evidence-based or certified decision-making aids.

3. Providing practice transformation support to primary care practitioners.

4. Providing comparative quality information on selected specialties.

5. Providing comparative pricing information on selected services.

6. One additional activity to support practitioners or providers in achieving PHM goals.

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description that is in place throughout the look-back period of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Evidence-based or certified decision-making aids**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factors 3 and 6 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners/providers in meeting their population health management goals by any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent care clinics or other care providers.

- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
  - Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
  - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
  - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First Surveys and Renewal Surveys: NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Report to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- *Pay-for-performance (P4P):* Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- *Shared savings:* Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- *Shared risk:* Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- *Two-sided risk sharing:* Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- *Capitation/population-based payment:* Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- *Numerator:* Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- *Denominator:* Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Clarifications

- Revised the look-back period from 6 months to 12 months for Renewal Surveys, for factor 14 (Element C).
- Added "throughout the look-back period" to the scope of review for documented process (Elements I, J).
- Clarified in the Explanation for *Factor 2: Members with special needs* that vision and hearing must be addressed to receive credit for the factor (Element I).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

Factor 2: **Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: **Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: **Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: **Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months; 12 months for factor 14.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. An overall summary of the participant's risk or wellness profile.

2. A clinical summary report describing individual risk factors.

3. Information on how to reduce risk by changing specific health behaviors.

4. Reference information that can help the participant understand the HA results.

5. A comparison to the individual's previous results, if applicable.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

Factor 2: **Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

Factor 3: **Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

Factor 4: **Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

Factor 5: **Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. Language is easy to understand.

2. Members' special needs, including vision and hearing, are addressed.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs. Vision and hearing must be addressed to receive credit for this factor.

Exception

Factors marked "No" in Element H are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each of the required seven health areas:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Clarifications

- Clarified the scope of review for First and Renewal Surveys to state that policies and procedures are in place throughout the look-back period (Element C).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months for factors 3, 5 and 11 (Element C).
- Moved the second paragraph of the Explanation under the subhead *Assessment and evaluation* (Element C).
- Clarified under the subhead *Assessment and evaluation* that the policies describe the process to collect information and document summary (Element C).
- Clarified the explanation under *factor 5 (social determinants of health)* to state that the organization considers more than one social determinant of health (Elements C, D).
- Moved "Time frames are specified in the case management plan" to be a subbullet under *Time frames for reevaluation* in the Explanation for factor 12 (Element C).
- Revised the look-back period to 12 months for Renewal Surveys, for all factors (Element D).
- Divided the Explanation for *Factor 1: Case management plans and goals* into two paragraphs and added text to clarify that goals must be both timebound and prioritized (Element E).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.

2. Discharge planner referral.

3. Member or caregiver referral.

4. Practitioner referral.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.

- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: **Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to the member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.**
15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months; 12 months for factors 3, 5 and 11.

Explanation

This is a structural requirement. The organization must present its own documentation.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases) and specify that the organization documents such assessment in the case management system and file.

***Factor 1:* Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

***Factor 2:* Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

***Factor 3:* Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

***Factor 4:* Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.

- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: Evaluation of community resources

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.
- Nutritional support.

Factor 12: Individual case management plan and goals

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frames for reevaluation of goals.
  - Time frames are specified in the case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.

Factor 13: Identification of barriers

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: Referrals to available resources

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: Follow-up schedule

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.

- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 13:* Assessment of barriers**[2]

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).

[2]Lorig, K. 2001. *Patient Education, A Practical Approach*. Thousand Oaks, CA: Sage Publications. 186–92.

- Self-administer medication (e.g., oral, inhaled or injectable).
- Self-administer medical procedures/treatments (e.g., change wound dressing).
- Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
- Maintain a prescribed diet.
- Chart daily weight, blood sugar.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification.

Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No", unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.

Excluded files from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

***Factor 1:* Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

***Factor 2:* Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

***Factor 3:* Initial assessment of activities of daily living**

The file or case record documents the results of the ADL assessment.

For ADLs with which the member needs assistance, the type of assistance and reason for need of assistance is recorded. The case manager does not need to describe ADLs the member does not need assistance with.

If the member does not need assistance with any ADLs, the case file or case notes reflect that no assistance is needed (e.g., "Member is fully independent with ADLs").

***Factor 4:* Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

***Factor 5:* Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

***Factor 6:* Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

***Factor 7:* Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

***Factor 8:* Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

***Factor 9:* Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 10:* Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need.

If no community resources are needed by the member, the case file or case notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples None.

Element E: Case Management: Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Excluded files from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date.

Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:* Case Management—Ongoing Management**

<table>
<tr><td colspan="2">Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)</td></tr>
<tr><td>Identification date: 1/5/2018</td><td>Initial Assessment Completed: 1/30/2018</td></tr>
<tr><td>Goal 1:</td><td>Secure stable housing for member by 2/11/2018. (Factor 1)</td></tr>
<tr><td colspan="2">Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. (Factor 1)

Strategies to achieve goal: Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.

Barriers to goal: Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)

Progress assessment: Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2018 and investigated group housing. (Factor 5)</td></tr>
<tr><td>Goal 1 completed:</td><td>2/16/2018.
Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)</td></tr>
</table>

Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2018) over 3–6 months. • Improve 5 points from baseline by 4/30/2018. • Improve 11 points from baseline by 7/30/2018. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2018. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2018. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2018. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**
Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via ***-***-****. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*****:** *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* **(Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. Obtaining feedback from members.

2. Analyzing member complaints.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys. For First Surveys: NCQA reviews the organization's most recent annual data collection and evaluation report.

For Renewal Surveys: During the most recent year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

During the previous year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months; at least once during the prior year for the percentage of members component of factor 1.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…?	Very Satisfied		Satisfied		Combined		Sample Size	90% Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan	75	60%	25	20%	100	80%	125	No
With how the case manager helped you get the care you needed	80	64%	35	28%	115	92%	125	Yes
With the case manager's attention and help with problems	70	56%	45	36%	1151	92%	125	Yes
With how the case manager treated you	85	68%	35	28%	120	96%	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action? (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2019	Total 2018
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2019; there were 26 in 2018. Totals by category were also lower in 2019 than in 2018. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact
—Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Clarifications

- Added "reports" as a data source and revised the look-back period for First and Renewal surveys to at least once during the prior year (Element A).
- Revised the Explanation for *factor 3 (interpretation of results)* (Element A).
- Revised the look-back period for First and Renewal Surveys to at least once during the prior year (Element B).
- Deleted the exception that reads, "This element is NA for 2018" (Element B).

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.

2. Comparison of results with a benchmark or goal.

3. Interpretation of results.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. NCQA also reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once in the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

The organization conducts an annual comprehensive, quantitative, analysis of the impact of the organization's PHM strategy.

Factor 1: **Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality), ***or***
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization analyzes feedback from at least two types of programs. The organization may use its complex case management member experience results and member experience results from one other program or service (e.g., disease management program or wellness program).

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: **Comparison of results**

The organization performs quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Measures are assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation is more than simply a presentation of results; it gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.

2. Act on one opportunity for improvement.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1: **Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: **Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

None.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Clarifications

- Element B: Provision of Member Data to the Delegate is now factor 5 in Element A: Delegation Agreement (Elements A).
- Revised the look-back period for new requirements for Renewal Surveys to 12 months from 6 months (Elements A, B, D).
- Revised the look-back period to from 6 months to 12 months for Renewal Surveys (Element B).
- Revised the use of collaborative language in the Related information (Element B).
- Added a *Related information* section and the use of collaborative language (Element C).

Deletions

- Eliminated *Element C: Provisions for PHI* and relettered the remaining elements.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Providing member and clinical data**

The organization provides:

- *Member experience data:* Complaints, CAHPS 5.0H survey results or other data collected on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

***Factor 6:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element B: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

This element applies if delegation was implemented in the look-back period.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For Interim Surveys: NCQA reviews the organization's review of the delegate's PHM program.

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

For Renewal Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples None.

Element D: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

Proposed Population Health Management (PHM) Strategy Overview

Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019

Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics

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Agenda

- 2018 National Committee for Quality Assurance (NCQA) Standards Change
- Population Health Management Conceptual Framework
- New Standards Overview
- Timeline and Accomplishments To Date
- Proposed PHM Strategy
- Discussion and Feedback

2018 NCQA Standard Changes

OLD

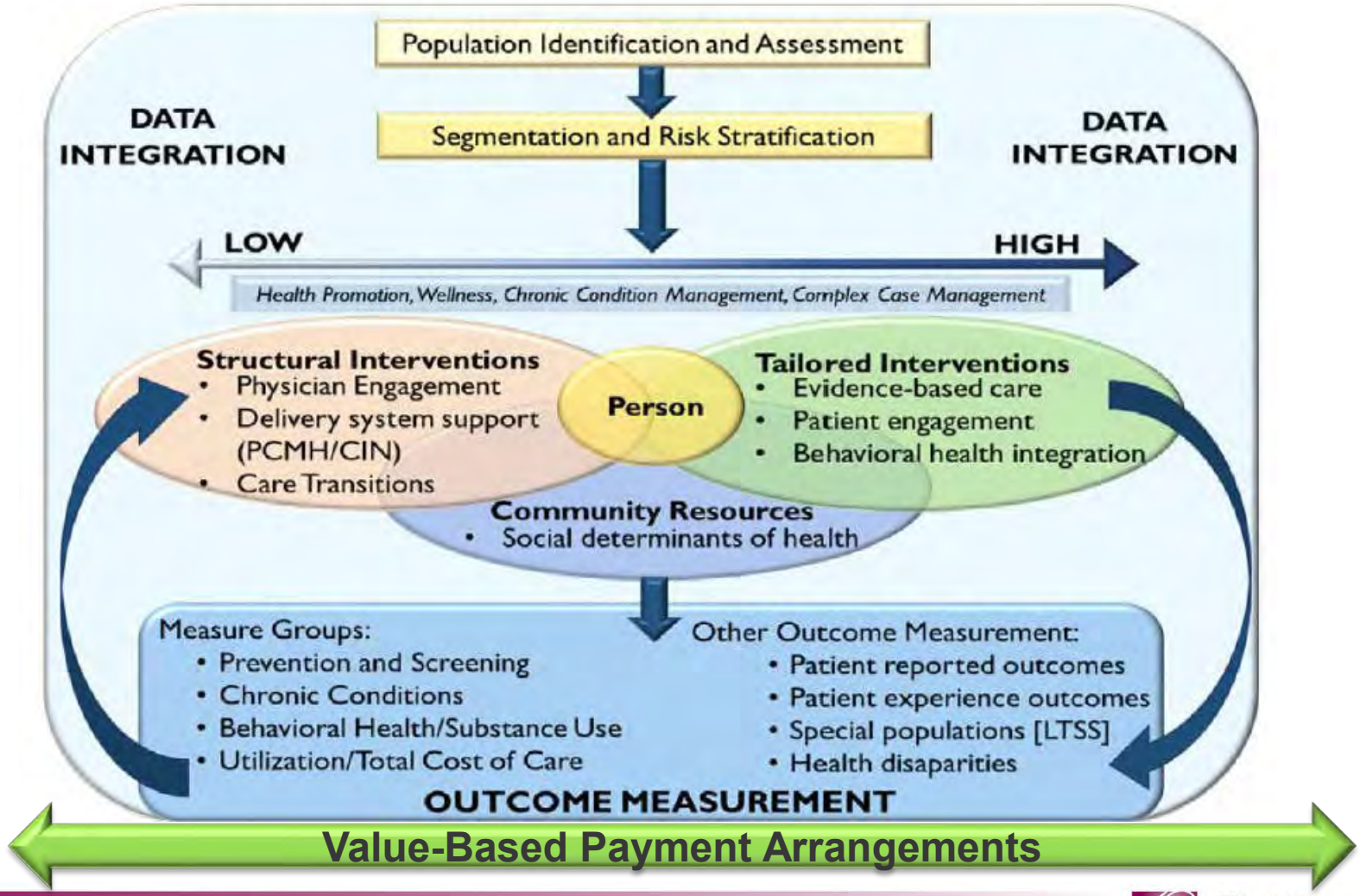
- Quality Improvement (QI) 5 Complex Case Management (CCM)
- QI 6 Disease Management (DM)
- Measuring Effectiveness by Individual Program

NEW

- Created Population Health Management (PHM) Standard Set
- Eliminated DM
- Move CCM under PHM
- Combined Measuring Effectiveness
- Added Standards
  - Data Integration
  - Delivery System Support

PHM Conceptual Framework

Figure 1.PHM Conceptual Model



Source: Diagram from ACAP presentation 3/29/17

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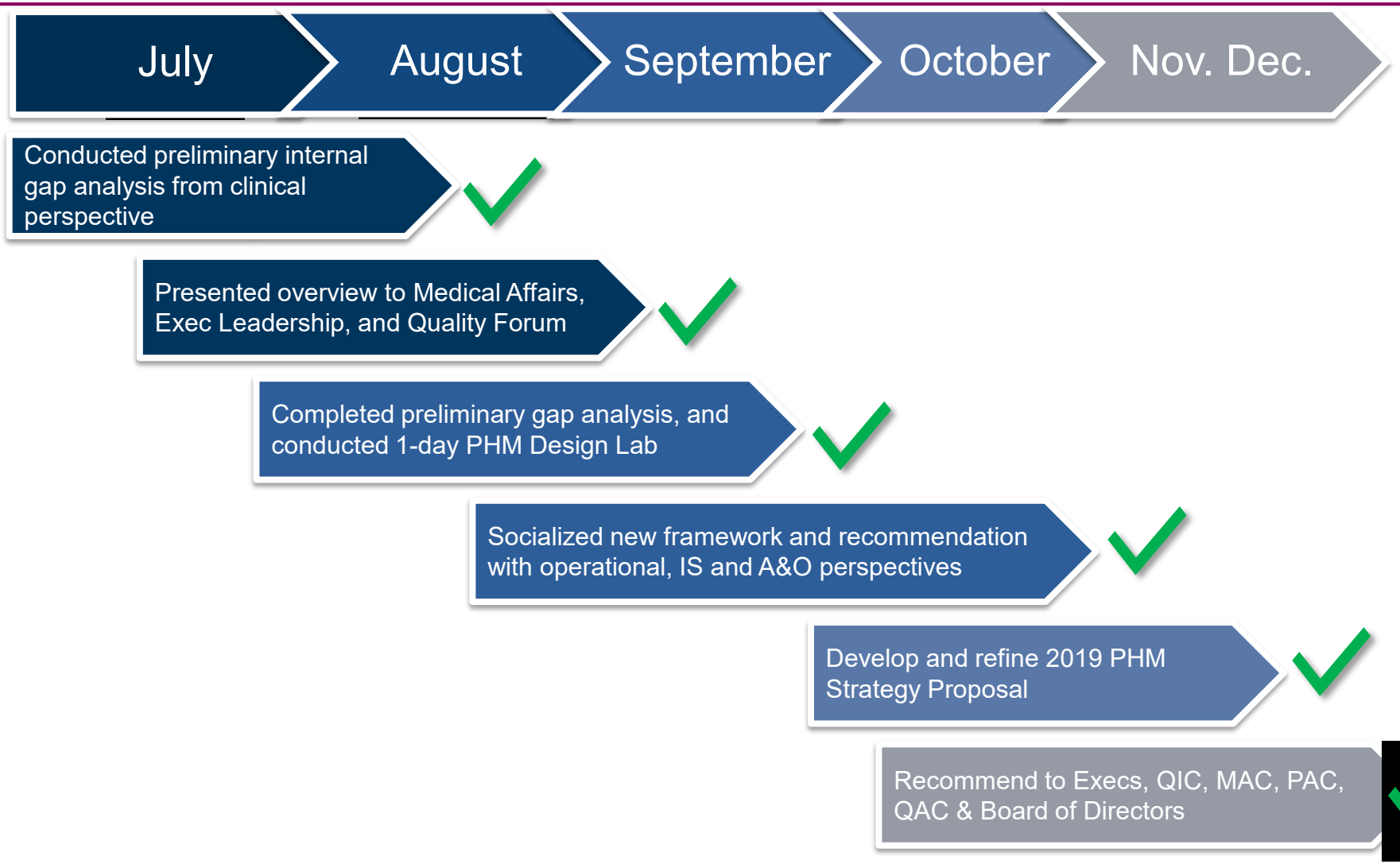
2018 Accomplishments



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PHM1 Element A: Strategy
(Effective July 2018)

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

1. Goals and populations targeted for each of the four areas of focus
   - Keeping members healthy
   - Managing members with emerging risk
   - Patient safety or outcomes across settings
   - Managing multiple chronic illnesses
2. Programs or services offered to members
3. **Activities that are not direct member interventions**
4. How member programs are coordinated
5. How members are informed about available PHM programs

Data Source: Documented Process

PHM2 Element A: Data Integration (Effective July 2018)

The organization assesses the needs of its population and determines actionable categories for appropriate interventions using:

1. Medical and behavioral claims or encounters
2. Pharmacy claims
3. Laboratory results
4. Health appraisal results
5. Electronic health records
6. Health services programs within the organization
7. Advanced data sources

Data source: Documented Process, Reports and Materials

PHM3 Element A: Practitioner or Provider Support (Effective July 2018)

The organization works with practitioners or providers to achieve population health management goals as part of Delivery System Support.

1. Sharing data
2. Offering evidence-based or certified decision-making aids
3. Providing practice transformation support to primary care practitioners
4. Providing comparative quality information on selected specialties
5. Comparative pricing information for selected services
6. One additional activity to support practitioners or providers in achieving PHM goals.

Data source: Documented Process and Materials

PHM1 Four Areas of Focus

Improving Outcomes Across All Settings

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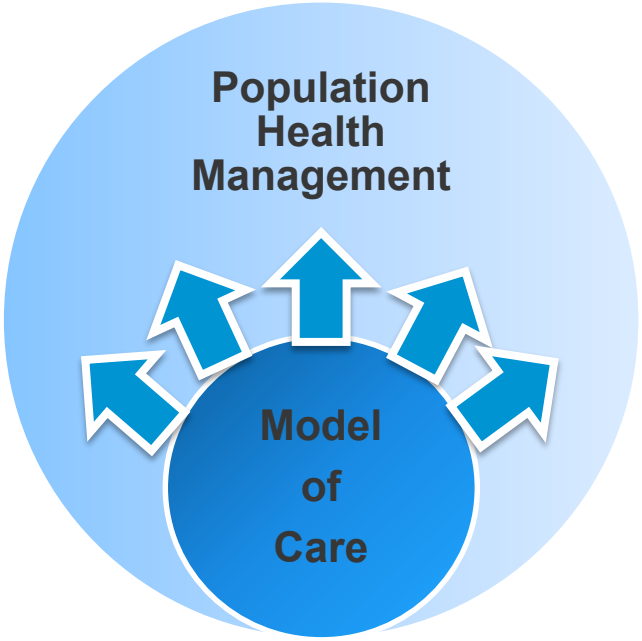
PHM Strategy Intent and Approach

The CalOptima Population Health Management 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.



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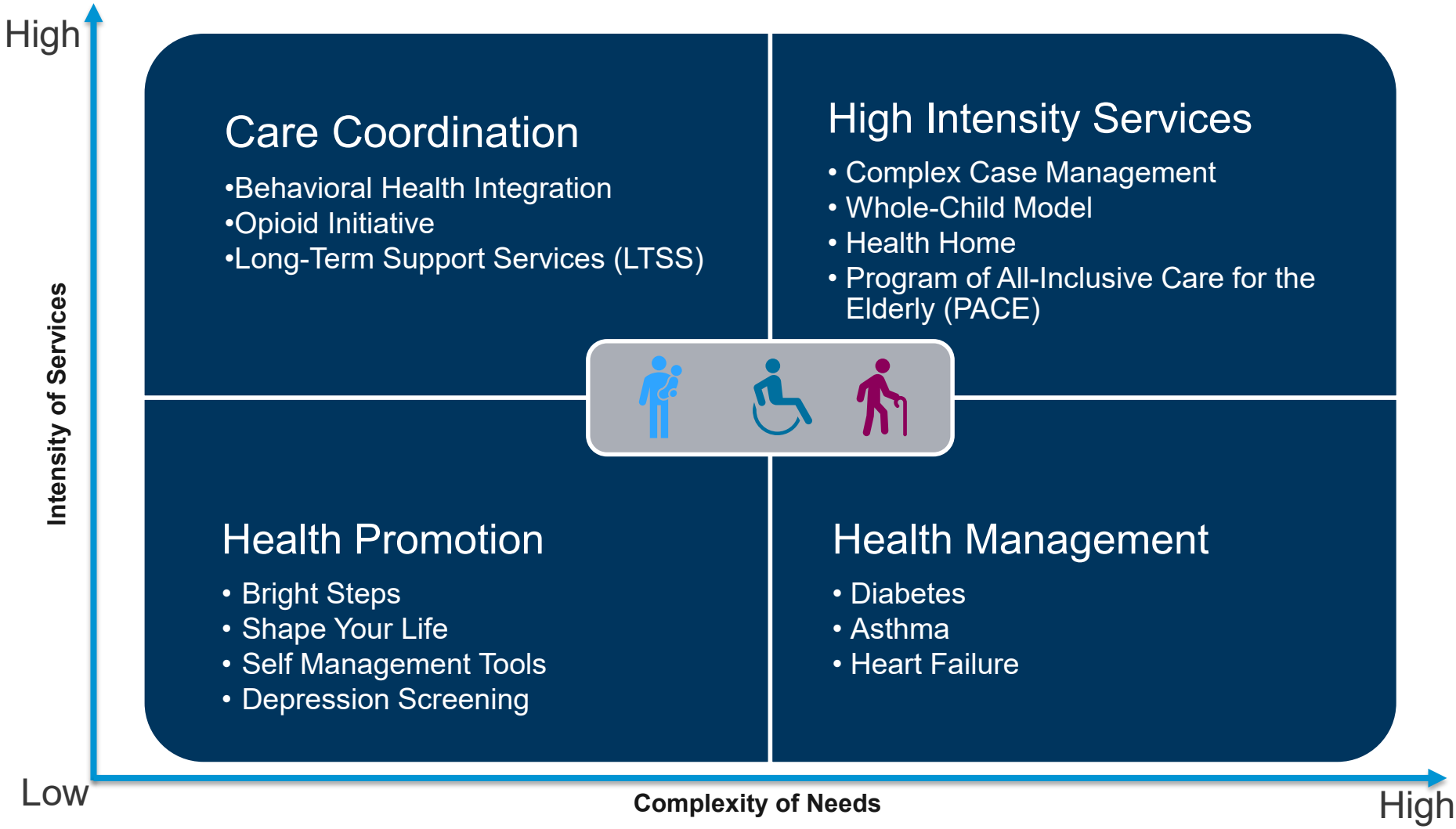
Current CalOptima Programs



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Keeping Members Healthy

Bright Steps — Improve Prenatal and Postpartum Care

- Goals:
  - Improve 2018 Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
  - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
  - Reduce NICU Days/K
- Target Population:
  - Members in the first trimester of pregnancy
- Description of Programs or Services:
  - Support a healthy pregnancy and postpartum care aligned with the Comprehensive Perinatal Services Program (CPSP) guidelines
- Activities:
  - Member outreach and coordination with CPSP providers
  - Direct health education and support CPSP interventions

Keeping Members Healthy (Cont.)

Shape Your Life — Prevent Childhood Obesity

- Goal:
  - Maintain HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year for the following:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
- Target Population:
  - Members age 5-18 with a Body Mass Index (BMI) equal to/or above the 85th percentile.
- Description of Programs or Services:
  - Health education and physical fitness activity program using evidence-based Kids-N Fitness curriculum conducted in 12 group classes in the community.
- Activities:
  - Active health education and member incentive for follow up visit with PCP after 6 consecutive classes

Managing Members with Emerging Risk

Health Management Programs — Improving Chronic Illness Care

- Goals:
  - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care (CDC)
  - Increase member satisfaction with program to 90% in 2018
  - Reduce ED and IP rates by 3% for program participants in 2018
- Target population:
  - Members at risk for Asthma, Diabetes and/or Heart Failure

Managing Members with Emerging Risk (cont.)

Health Management Programs — Improving Chronic Illness Care (cont.)

- Description of Programs or Services:
  - Integrated health management and disease prevention programs to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention.
- Activities:
  - Member outreach
  - Health education classes
  - Self-management Tools
  - Telephonic coaching
  - Explore Board approval to expand member engagement leveraging virtual technology such as secured telehealth, texting, and remote patient monitoring (New Idea)

Managing Members with Emerging Risk (Cont.)

Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction

- Goals:
  - Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
  - Decrease Emergency Department utilization related to substance disorder
- Target Population:
  - Members with diagnosis of opioid substance abuse disorder
- Description of Programs or Services:
  - A multi-department and health collaborative aimed at reducing opioid misuse and related death
- Activities:
  - Pharmacy lock-in program
  - Case management outreach
  - Physician academic detailing for safer prescribing
  - Develop access to Medication Assisted Treatment (MAT)

Patient Safety

Behavioral Health Treatment (BHT) Services

- Goal: Establish baseline in 2018
- Target Population:
  - Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate
- Description of Programs or Services:
  - Provide medically necessary BHT services to children with ASD. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- Activities:
  - Treatment planning and implementation
  - Direct observation and measurement
  - Functional analysis

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team

- Goal:
  - Achieve and sustain 100% compliance of all Facility Site Review (FSR) audits year-over-year for primary care practices.
- Target Population:
  - Medi-Cal adults and children accessing primary care.
- Description of Programs or Services:
  - Enhancing the existing FSR nursing function by training nurses QI facilitation skills to address any gaps from FSR audit to improve compliance with practice health and safety standards at the practices sites of the CalOptima Community Network (CCN).

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team (cont.)

- Activities:
  - Develop Practice Facilitator function of the existing Facility Site Review (FSR) nurses to identify opportunities to improve practice site health and safety, provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices.
  - Provide QI technical support to the safety net community clinics, Federally Qualified Health Center (FQHC), and PACE to promote patient safety practices.

Managing Members with Multiple Chronic Illnesses

Whole Child Model — Ensure Whole-Child Centric Quality and Continuity Care for Children with California Children's Condition (CCS) Eligible Conditions

- Goal:
  - Improve Children and Adolescent Immunization HEDIS measures to ≥ 75th percentile by December 2020 (excluding children and adolescent under cancer treatment)
- Targeted Population:
  - Children with CCS eligible conditions
- Description of Programs or Services:
  - The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results.
- Activities:
  - Care Management
  - Personal Care Coordinator (PCC)

Managing Members with Multiple Chronic Illnesses (Cont.)

Health Home Program (HHP) Pilot — Improve Clinical Outcomes of Members With Multiple Chronic Conditions and Experiencing Homelessness

- Goal: Establish baseline in 2019
- Target Population:
  - Highest risk 3-5% of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria as determined by Department of Health Care Services (DHCS).
- Description of Programs or Services:
  - A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- Activities:
  - High touch core services as defined by DHCS

Delivery System Support (PHM3A)

Delivery System for Practitioner/Provider Support

- Information Sharing
  - Increase actionable data sharing to support academic detailing to improving outcomes across all settings.
- Practice Transformation Technical Assistance (New Idea)
  - Build upon internal FSR and QI capability to offer practice transformation support through Lean QI training, practice site facilitations, and/or individualize technical assistance to improve member experience.
- Provider Coaching (New Idea)
  - Offer individual provider coaching session and office staff workshops to improve quality of services and patient experience to targeted high volume CCN provider practices.

NCQA Timeline

Discussion and Feedback

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Attachment 9 to May 7, 2020 Board of Directors Meeting– Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
mPulse Mobile	16530 Ventura Blvd., Suite 500	Encino	CA	91436

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Contracts and Funding to Support the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Response to COVID-19

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with a:

1. Virtual care solution provider for PACE members recommended by staff through an informal bidding process for the period of May 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $9,500; and

2. Mobile phlebotomy services provider for blood draw services in PACE member homes for the period of April 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $12,000.

Background
CalOptima PACE currently serves approximately 402 members via the CalOptima PACE center and four operating alternative care settings. Eligibility for PACE is based on individuals requiring nursing home level of care, yet able to continue living in the community safely. The average age of PACE members is 73. PACE members have multiple co-morbidities, presenting as the highest risk population for complications from COVID-19.

Staff are taking definitive action to reduce the spread of COVID-19 and maintain the health of PACE members in the community. The operational changes made thus far represent a significant reinvention of the PACE model to a home-based system of care and support. At this time, the PACE center is closed to visitors. To comply with social distancing recommendations from the Centers for Disease Control (CDC), PACE day center services have been suspended. The clinic continues to operate with extremely limited in-person visits, now relying on drive-thru, telephonic and virtual visits. These operational changes to remote monitoring, telehealth and delivery of critical supplies and medications has been built upon existing contractual relationships. As services gaps are identified, staff plans to continue to recommend additional contractual relationships to meet member needs.

Discussion
Virtual care is a valuable tool for staff to support PACE members in their home environment. As an interim solution, PACE is using FaceTime and GoogleDuo to connect with members and provide virtual visits for doctors, nurses, therapists and social workers. The current COVID-19 response is expected to extend into the coming months and staff recommend a HIPAA-compliant, cross platform virtual care solution. An interdepartmental team of CalOptima staff, including PACE management, Information Services (Security and Applications) managers, a purchasing manager and the Privacy Officer has

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reviewed potential solutions based on an established scope of work. Staff estimate that the cost for these services will range from $200 to $1,000 per month, but will vary depending on vendor packages and the number of virtual care users. In accordance with CalOptima Purchasing Policy GA.5002, staff recommend that the Board authorize the CEO to select a vendor based on an informal bidding process, which includes vendor demonstrations of each product in the context of CalOptima system requirements, entering into an agreement with the selected vendor, and the expenditure of unbudgeted funds from reserves in an amount up to $9,500 to cover anticipated licensing fees and associated expenses with virtual care implementation through June 30, 2020.

While virtual care is a valuable tool, not all provider encounters can be accomplished through a virtual platform. Physical components, such as the collection of vitals and blood draws, usually completed in the PACE clinic, are not possible remotely. To reduce the risk of PACE members going to the PACE clinic or a contracted laboratory for blood draw services, staff recommend contracting with a mobile phlebotomy service provider capable of completing home visits for stat and routine blood draw services, including venipuncture blood draws, capillary blood draws, kit draws, as well as specimen collection. Providers in this market often contract for a case or capitated rate. This type of bundled rate structure is common for mobile phlebotomy contracts with HMO, IPA, and other health providers in the community. Staff recommend contracting for a flat rate of up to $65 per visit, to include supplies, order processing, technician personnel, and transportation to reach the member and deliver the specimen to the PACE contracted lab. Access to this service is critical in response to COVID-19, and is also expected to be beneficial post-public health crisis for weekend and stat laboratory orders.

Fiscal Impact

The recommended actions to contract with a telehealth solution for PACE members for the period of May 1, 2020, through June 30, 2020, and to contract with a mobile phlebotomy services provider for the period of April 1, 2020, through June 30, 2020, are unbudgeted items. The fiscal impact to the current year operating budget for both is estimated at $21,500. An allocation from existing reserves will fund the recommended actions. If expenses are anticipated beyond June 30, 2020, staff will address them in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions.

Rationale for Recommendation

Access to telehealth and mobile in-home phlebotomy are critical to the reinvented PACE model operating in response to COVID-19.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *04/29/2020*

Authorized Signature **Date**

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Attachment 1 to May 7, 2020 Board of Directors Meeting– Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Doxy LLC	3563 S. Mustang Drive	Ontario	CA	91761
Vsee Labs, Inc.	3188 Kimlee Drive, Suite 100	San Jose	CA	95132
SnapMD, Inc.	121 Lexington Drive, Suite 412	Glendale	CA	91203
Thera-Link	P.O. Box 13709	Birmingham	AL	35202
PhlebExpress	32819 Temecula Pkwy. Suite B	Temecula	CA	92591

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Authorizing Amendment to Medi-Cal Ancillary Contracts for Skilled Nursing Facilities

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend Medi-Cal Ancillary contracts for all Skilled Nursing Facilities (SNF), to standardize and, in aggregate, increase the rates effective June 1, 2020.

Background/Discussion
In keeping with its mission to provide the members with access to covered, medically necessary healthcare services, CalOptima continues efforts to work with hospitals to ensure that members are discharged to the appropriate level of care as promptly as possible. CalOptima's contracted network of Skilled Nursing Facilities (SNFs) plays a vital role in providing services to many members who are discharged from hospitals and require Short Stay services for their care. Short Stay services/benefits include:

- Over the counter drugs
- Semi-private rooms
- Meals and nutritional assessment/evaluation
- Recreational activities
- Pain management
- Nursing care and restorative nursing
- Respiratory and oxygen supplies and services
- Administration of medications
- Medical supplies
- X-Ray/Radiology Services
- Laboratory Services
- Medical/In-house nursing supplies
- Discharge planning
- Standard Durable Medical Equipment

CalOptima management has developed and proposes to implement standardized rates for the four levels of care that SNFs provide to provide equitable and sustainable reimbursement across all contracted SNFs in Orange County.

Previously, these SNFs were contracted with individually negotiated rates. Overall, this proposed standardization represents an increase in the aggregate, with most SNFs receiving a higher rate, and a smaller number receiving a reduction. Management recommends approval of this standardized rate

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approach for the purpose of eliminating individualized negotiated rates and handling all contracted SNF providers equally. CalOptima staff seeks to support its providers, including a change in rates for Medi-Cal Short Stay benefits provided at SNFs. For most facilities, this proposal will result in a rate increase.

To that end, staff recommends amending the Medi-Cal Ancillary contracts for SNFs for Short Stay benefits to standardize rates beginning June 1, 2020.

Fiscal Impact
The recommended action to amend Medi-Cal Ancillary contracts for SNFs to increase and standardize rates has an estimated annual fiscal impact of $1.6 million. The anticipated current year fiscal impact for the period June 1, 2020, through June 30, 2020, is $131,000. This is a budgeted item and was included in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Management will include updated medical expenses in the upcoming CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation
Contract rate standardization and rate increase for Medi-Cal members' Short Stay benefits at SNFs would demonstrate CalOptima's ongoing commitment to work collaboratively with providers and adapt to the current opportunities to address the access needs of our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Approval of Resolution Renaming Seats on the CalOptima Board of Directors' Member Advisory Committee

Contact

Belinda Abeyta, Executive Director, Operations, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

A. Adopt Resolution No. 20-0507-01, to rename two Member Advisory Committee (MAC) Representative seats as follows:

1) Rename seat for Medically Indigent Persons Representative to Medical Safety Net Representative;
2) Rename seat for Persons with Mental Illness Representative to Mental/Behavioral Health Representative; and
3) Authorize updates to CalOptima Policy AA.1219a: Member Advisory Committee to reflect the recommended changes.

Background

The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of 15 voting members, with each seat representing a constituency or population that CalOptima serves. The Board is responsible for appointment of MAC members.

MAC is recommending renaming two MAC Representatives to be more inclusive of the terminology and titles currently used in healthcare and the members CalOptima serves within the community.

Discussion

Consistent with the Board's policy of encouraging member and provider involvement in the ongoing refinement of the CalOptima program, the MAC believes that the Medically Indigent Representative seat should be renamed the Medical Safety Net Representative seat, and that the Persons with Mental Illness seat should be renamed the Mental/Behavioral Health Representative seat. These recommendations were made during a MAC joint recruitment ad hoc review of all seats on the MAC and the PAC. At the February 25, 2020 Special MAC meeting, members considered the renaming of the two representatives and agreed to recommend these changes. There is no proposed change to the number of seats on MAC.

If the proposed changes are approved by the Board, CalOptima policy AA.1219a: Member Advisory Committee would be updated accordingly.

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
MAC is recommending renaming two seats to better reflect the terminology and titles used in the current healthcare environment and the members CalOptima serves.

Concurrence
Member Advisory Committee Recruitment Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
1. Resolution Number 20-0507-01
2. AA.1219a Member Advisory Committee Policy

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 20-0507-01

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

APPROVE NAME CHANGES TO MEDICALLY INDIGENT AND PERSONS WITH MENTAL ILLNESS REPRESENTATIVES

WHEREAS, the CalOptima Board of Directors established the Member Advisory Committee (MAC) pursuant to Resolution No. 2-14-95 to represent the constituencies served by CalOptima and to advise the Board of Directors and later amended to add a Vice Chair position pursuant to Resolution No. 16-0804-01; and

WHEREAS, the members of the MAC recommend changing the name of the Medically Indigent Representative seat to the Medical Safety Net Representative seat and changing the name of the Persons with Mental Illness Representative to the Mental/Behavioral Health Representative.

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby approves the recommended name changes and changes the name of the Medically Indigent Representative seat to the Medical Safety Net Representative seat, and changes the name of the Persons with Mental Illness seat to the Mental/Behavioral Health Representative effective May 7, 2020. The seats comprising the MAC are now:

a. Adult Beneficiaries
b. Behavioral/Mental Health
c. Children
d. Consumer
e. Family Support
f. Foster Children
g. Long-Term Services and Supports (LTSS)
h. Medi-Cal Beneficiaries
i. Medical Safety Net
j. Orange County Health Care Agency Representative (Standing Seat)
k. Orange County Social Services Agency (Standing Seat)
l. Persons with Disabilities
m. Persons with Special Needs
n. Recipients of CalWORKs
o. Seniors

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of May 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

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

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

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Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative - External

I. PURPOSE

This policy describes the composition and role of CalOptima's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's MAC.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), MAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages Member involvement in the CalOptima program.

C. MAC ~~Mmm~~embers shall recuse themselves from voting or from decisions where a conflict of interest may ~~exist, and~~exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. All MAC ~~Mmm~~embers shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995) and 11-1103 (effective in November 3, 2011), MAC shall be comprised of fifteen (15) voting ~~Mmm~~embers, each seat representing a constituency served by CalOptima.

1. Two (2) of the fifteen (15) positions are standing seats and are held by the Orange County Health Care Agency (HCA) and the Social Services Agency (SSA).

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2. The remaining thirteen (13) ~~members~~Mmembers shall serve a two (2) year term with no limits on the number of terms a representative may serve.

   a. One (1) of the remaining thirteen (13) positions shall be a dedicated Ce~~c~~onsumer seat. ~~A dedicated consumer seat shall be defined as a Member or a Member's Authorized Representative from any of CalOptima's programs.~~

   b. The two (2) year term shall coincide with CalOptima's fiscal year (i.e., July 1 through June 30).

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult ~~beneficiaries~~b~~B~~eneficiaries;

   b. Behavioral/Mental Health;

   ~~b.~~c. Children;

   d. Consumer;

   ~~c.~~e. Family Support Representative;

   ~~d. Former Developmental Center Members or consumers;~~

   ~~e.~~f. Foster ~~children~~C~~c~~hildren;

   ~~f.~~g. Long-Term Services a~~A~~nd Supports (LTSS) ~~Representative~~;

   ~~g.~~h. Medi-Cal ~~beneficiaries~~B~~b~~eneficiaries;

   ~~h.~~i. Medical~~ly~~ Safety Net ~~indigent persons~~;

   ~~i.~~j. Orange County HCA;

   ~~j.~~k. Orange County SSA;

   ~~k.~~l. Persons with ~~disabilities~~D~~d~~isabilities;

   ~~l.~~m. Persons with Special Needs;

   ~~m. Persons with mental illness;~~

   n. Recipients of CalWORKs; or

   o. Seniors.

F. MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

   1. The MAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately half of the MAC seats' terms expire, alternating between six (6) vacancies one (1) year and seven (7) vacancies the subsequent year. Standing seats in MAC are not impacted by term expiration.

2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two (2) year term.

G. Special Elections

1. Special elections for MAC shall occur under the following circumstances:

a. When a MAC seat is vacant due to the resignation of a sitting MAC ~~member~~~~M~~member; or

b. The current MAC ~~member M~~member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC ~~member M~~member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

H. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

I. On an annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) ~~consecutive one (1)~~ year term~~s~~.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) ~~members M~~members to serve on the ad hoc subcommittee. MAC ~~members~~~~M~~members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

L. MAC ~~members~~ Mmembers shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC ~~member~~ Mmember provides notification of an absence to CalOptima staff prior to the MAC meeting. CalOptima staff shall maintain an attendance log of the MAC ~~members~~Mmembers' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC ~~members'~~ Mmembers' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the MAC as standing ~~members~~Mmembers.

a. The MAC shall include the Public Health Officer (or his or her designee) of the HCA and the Director (or his or her designee) of the SSA.

b. SSA and HCA representatives shall serve as standing ~~members~~Mmembers and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed ~~members~~Mmembers shall constitute a quorum.

a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not be limited to, the following:

a. Outreach to the respective Member community;

b. Placement of vacancy notices on the CalOptima Website; and

~~b.~~c. Advertisement of vacancies in local newspapers in Threshold Languages.

~~c. Advertisement of vacancies in local newspapers in Threshold Languages.~~

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. The MAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

D. CalOptima shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) ~~m~~Mmembers, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

a. Ad hoc subcommittee ~~M~~m~~m~~embers shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

b. Ad hoc subcommittee ~~members~~ Mmembers shall individually evaluate and select a chair and vice chair.

c. At the discretion of the ad hoc subcommittee, subcommittee ~~members~~ Mmembers may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a chair, vice chair and a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of MAC's recommendation, the new MAC ~~members'~~ Mmembers' terms shall be effective July 1.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima shall provide new MAC ~~members M~~members with a new member orientation.

IV. ATTACHMENTS

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee Applicant Evaluation Tool
D. Member Advisory Committee Seat Descriptions

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Policy AA.1000: Glossary of Terms~~
~~C. CalOptima Policy AA.1100: Glossary of Terms~~
~~D.~~B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
~~E.~~C. CalOptima Board Resolution 2-14-95
~~F.~~D. CalOptima Board Resolution 06-0707
~~G.~~E. CalOptima Board Resolution 11-1103
~~H.~~F. CalOptima Board Resolution 13-0307
~~I.~~G. CalOptima Board Resolution 15-08-06-02
~~J.~~H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
08/11/17	Department of Health Care Services
09/15/14	Department of Health Care Services

VII. BOARD ACTIONS

Date	Meeting
06/01/17	Regular Meeting of the CalOptima Board of Directors
08/04/16	Regular Meeting of the CalOptima Board of Directors
08/06/15	Regular Meeting of the CalOptima Board of Directors
03/07/13	Regular Meeting of the CalOptima Board of Directors
11/03/11	Regular Meeting of the CalOptima Board of Directors
07/07/06	Regular Meeting of the CalOptima Board of Directors
02/14/95	Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

Action~~Version~~	Date	~~Policy Number~~Policy	Policy Title	~~Line(s) of Business~~Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal

~~Version~~ Action	Date	~~Policy Number~~ Policy	Policy Title	~~Line(s) of Business~~ Program(s)
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	~~05/01/2020~~TBD	AA.1219a	Member Advisory Committee	Medi-Cal

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IX. GLOSSARY

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.~~An enrollee beneficiary of a CalOptima program.~~
Member Advisory Committee	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the ~~Group~~ Population Needs Assessment (PG~~G~~NA).

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
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This policy describes the composition and role of CalOptima's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's MAC.

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B. CalOptima's Board encourages Member involvement in the CalOptima program.

C. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995) and 11-1103 (effective in November 3, 2011), MAC shall be comprised of fifteen (15) voting members, each seat representing a constituency served by CalOptima.

1. Two (2) of the fifteen (15) positions are standing seats and are held by the Orange County Health Care Agency (HCA) and the Social Services Agency (SSA).

2. The remaining thirteen (13) members shall serve a two (2) year term with no limits on the number of terms a representative may serve.

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a. One (1) of the remaining thirteen (13) positions shall be a dedicated Consumer seat.

b. The two (2) year term shall coincide with CalOptima's fiscal year (i.e., July 1 through June 30).

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

a. Adult beneficiaries;

b. Behavioral/Mental Health;

c. Children;

d. Consumer;

e. Family Support Representative;

f. Foster children;

g. Long-Term Services and Supports (LTSS);

h. Medi-Cal beneficiaries;

i. Medical Safety Net;

j. Orange County HCA;

k. Orange County SSA;

l. Persons with disabilities;

m. Persons with Special Needs;

n. Recipients of CalWORKs; or

o. Seniors.

F. MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately half of the MAC seats' terms expire, alternating between six (6) vacancies one (1) year and seven (7) vacancies the subsequent year. Standing seats in MAC are not impacted by term expiration.

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a. When a MAC seat is vacant due to the resignation of a sitting MAC member; or

b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

H. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

I. On an annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

L. MAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima staff prior to the MAC meeting. CalOptima staff shall maintain an attendance log of the

MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the MAC as standing members.

   a. The MAC shall include the Public Health Officer (or his or her designee) of the HCA and the Director (or his or her designee) of the SSA.

   b. SSA and HCA representatives shall serve as standing members and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not be limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Website; and

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. The MAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

D. CalOptima shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

   a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a chair, vice chair and a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima shall provide new MAC members with a new member orientation.

IV. ATTACHMENTS

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee Applicant Evaluation Tool
D. Member Advisory Committee Seat Descriptions

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Board Resolution 2-14-95
D. CalOptima Board Resolution 06-0707
E. CalOptima Board Resolution 11-1103
F. CalOptima Board Resolution 13-0307
G. CalOptima Board Resolution 15-08-06-02
H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
08/11/17	Department of Health Care Services
09/15/14	Department of Health Care Services

VII. BOARD ACTIONS

Date	Meeting
06/01/17	Regular Meeting of the CalOptima Board of Directors
08/04/16	Regular Meeting of the CalOptima Board of Directors
08/06/15	Regular Meeting of the CalOptima Board of Directors
03/07/13	Regular Meeting of the CalOptima Board of Directors
11/03/11	Regular Meeting of the CalOptima Board of Directors
07/07/06	Regular Meeting of the CalOptima Board of Directors
02/14/95	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	TBD	AA.1219a	Member Advisory Committee	Medi-Cal

IX. GLOSSARY

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.
Member Advisory Committee	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

CalOptima Seeks Candidates to Participate on its Member Advisory Committee

The CalOptima Board of Directors welcomes input and recommendations from the community regarding issues concerning CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the Member Advisory Committee (MAC).

The **Member Advisory Committee** advises the CalOptima Board of Directors and staff. The CalOptima MAC is composed of 15 members representing the various constituencies that CalOptima serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning CalOptima programs as directed by the CalOptima Board.
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima programs.
- Initiate recommendations on issues for study to the CalOptima Board for their approval and consideration.
- Facilitate community outreach for CalOptima and the Board.

Currently, CalOptima is seeking a candidate to participate on its Member Advisory Committee. **Service on the MAC is voluntary and with no salary.** The following two-year seat is available:

- **Consumer Representative**

The committee encourages interested individuals who receive Medi-Cal or an Authorized Family Member of a Medi-Cal recipient to apply. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application along with a **biography or résumé** to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

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MEMBER ADVISORY COMMITTEE

Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____
Address: _____ Cell Phone: _____
City, State, ZIP: _____ Fax Number: _____
Email: _____

This seat serves a two-year term ending June 30, 2020.
☐ **Consumer**

Current position (e.g., title, student, volunteer, retired, etc.): _____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the MAC?

1b. Include any relevant community experience.

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

2b. Include relevant experience related to working with diverse populations.

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3. What is your current understanding of managed care systems and/or CalOptima?

_____

_____

_____

_____

4a. Please explain why you wish to serve on CalOptima's MAC.

_____

_____

_____

_____

4b. Please explain why you would be a qualified representative to serve on the MAC.

_____

_____

_____

_____

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)?

_____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

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PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's web site, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on the Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

☐ **FAMILY MEMBER/CAREGIVER APPLICANT**

I understand that by my family member or caregiver applying to serve on the MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) **Date**

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for or appointment to the CalOptima Member Advisory Committee**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Member Advisory Committee.**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Attn: Cheryl Simmons
Customer Service Department
505 City Parkway West
Orange, CA 92868

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I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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Submit the completed application, your biography or résumé, and signed authorization forms to the address below or by email or secure fax:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons
Email: csimmons@caloptima.org
Secure Fax: 714-571-2479

For questions, call 1-714-347-5785.

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CalOptima Seeks Candidates to Participate on its Member Advisory Committee 2020–2022

The CalOptima Board of Directors welcomes input and recommendations from the community regarding issues concerning CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the Member Advisory Committee (MAC).

The **Member Advisory Committee** advises the CalOptima Board of Directors and staff. The CalOptima MAC is composed of 15 members representing the various constituencies that CalOptima serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning CalOptima programs as directed by the CalOptima Board.
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima programs.
- Initiate recommendations on issues for study to the CalOptima Board for their approval and consideration.
- Facilitate community outreach for CalOptima and the Board.

At this time, CalOptima is seeking candidates to participate on its Member Advisory Committee. **Service on the MAC is voluntary and with no salary.** The following two-year seats are available for representatives of:

- **Children**
- **Foster Children**
- **Long-Term Services and Supports**
- **Medically Indigent Persons**
- **Persons with Mental Illness**
- **Persons with Special Needs**

The committee encourages interested individuals with knowledge and support of Medi-Cal and Medicare. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application by **March 31, 2020,** along with a **biography or resume** to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

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MEMBER ADVISORY COMMITTEE
Community Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____

The following positions will serve a two-year term beginning July 1, 2020, through June 30, 2022.

Please indicate the seat for which you are applying:

☐ **Children**

☐ **Foster Children**

☐ **Long-Term Services and Supports**

☐ **Medically Indigent Persons**

☐ **Persons with Special Needs**

Current position (e.g., title, student, volunteer, retired, etc.): _____

_____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the Member Advisory Committee (MAC)?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

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2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima?

4a. Please explain why you wish to serve on CalOptima's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)? Please specify: _____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published with the contact information removed as part of the Board Materials that are available on CalOptima's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

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Submit with a biography or resume to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

For questions, call **714-347-5785**.

Applications accepted through March 31, 2020

Completed applications may be submitted via fax to 714-571-2479 or email to csimmons@caloptima.org

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Member Advisory Committee
2020–2022
Position Descriptions

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to Office of the Inspector General (OIG)/General Services Administration (GSA) verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks.

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Long-Term Services and Supports Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who are in:
  - Intermediate Care Facility — Developmentally Disabled
  - Intermediate Care Facility — Developmentally Disabled — Nursing
  - Intermediate Care Facility — Developmentally Disabled — Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities — Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medically Indigent Persons Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who utilize and are treated by:
  - Federally Qualified Health Centers (FQHCs)
  - Community Clinics
  - Recuperative Care Providers
  - Low Income Assistance Providers
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

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Persons with Mental Illness Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologist
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-Doctoral (BCBA-D)
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

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CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

Member Advisory Committee

MAC Seat:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1a. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
1b. Include relevant community involvement	1–5	_____
2a. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
2b. Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4a. Expressed desire to serve on the MAC	1–5	_____
4b. Explanation why applicant is a qualified representative	1–5	_____
5. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
6. Availability and willingness to attend meetings	Yes/No	_____
7. Supportive references	Yes/No	_____

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Total Possible Points 35

Name of MAC Evaluator

Total Points Awarded

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2020 MAC Position Description

Adult Beneficiaries Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima adult members in pursuit of their health and wellness
- At least three years of employment in the field and/or three years of experience in field or "is a member with lived-experience"
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Representative (Formerly Persons with Mental Illness Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members

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- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Consumer Representative

Position Description

- Must be a current CalOptima Medi-Cal member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Family Support Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima families in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

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Long Term Services and Supports Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who are in:
  - Intermediate Care Facility – Developmentally Disabled
  - Intermediate Care Facility – Developmentally Disabled – Nursing
  - Intermediate Care Facility -Developmentally Disabled – Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities – Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medi-Cal Beneficiaries Representative

Position Description

- Current CalOptima Medi-Cal member or current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal beneficiaries
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima Medi-Cal members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC

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meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medical Safety Net Representative (Formerly Medically Indigent Persons Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who utilize and are treated by:
  - Federally Qualified Health Centers (FQHCs)
  - Community Clinics
  - Recuperative Care Providers
  - Low Income Assistance Providers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with disabilities in pursuit of their health and wellness
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members

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- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima CalWORKs members in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience as a CalWORKs recipient or representative
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima seniors including, but not limited to:
  - Community Based Adult Services (CBAS) Centers
  - Community-Based Organization (CBO)
  - Senior centers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Care Agency Representative (Standing Seat)

Position Description

- Represented by the Orange County Health Care Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima members and is appointed by the Orange County Social Services Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Board of Directors' at monthly meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Authorizing Contract with an Executive Search Firm for Chief Executive Officer Recruitment

Contact
Brigette Gibb, Executive Director, Human Resources (714) 246-8400

Recommended Actions
1. Consistent with Board-approved Purchasing Policy, authorize staff to enter into a contract with the assistance of Legal Counsel, with ~~either~~:
   - Witt Kieffer and include a carve out provision to reduce fees should the Board appoint the interim Chief Executive Officer (CEO) as the permanent CEO prior to 120 days after contract execution; ~~or~~
   - ~~Korn Ferry International and include a carve out provision to reduce fees should the Board appoint the interim CEO as the permanent CEO at any time during the recruitment~~.

Rev. 5/7/20

Background
Michael Schrader has served as CalOptima's CEO for the past seven years and recently informed the Board of Directors that his last day of service with CalOptima will be May 3, 2020. At the Board's April 2, 2020 meeting, it authorized a contract with Richard Sanchez, the former Director of the Orange County Health Care Agency, to serve as CEO on an interim basis.

Discussion
Mr. Schrader's departure will leave a vacancy in CalOptima's highest level staff position. CalOptima's CEO is appointed by and serves at the pleasure of the Board. The CEO provides organizational strategic direction, collaborates with the executive team and business unit leaders and is responsible for acting as the duly authorized representative of CalOptima in all matters in which the Board has not formally designated some other person to act.

In order to fill the CEO vacancy on a permanent basis, it is essential to recruit properly qualified candidates in a highly competitive market. In order to conduct a nationwide executive search, staff recommends contracting with a qualified executive search firm. These firms possess the expertise to determine a pool of potential candidates, narrow the field to promising candidates, and then ensure that the Board interviews the most qualified candidates.

CalOptima has successfully utilized executive search firms in the past to locate other executive officers and estimates an executive search will take approximately three - six months to complete.

The executive search firms listed on the attachment charge fees in the range of 25% to 33.33% of the anticipated total cash compensation. Administrative costs of up to 12% plus travel-related reimbursement are additional.

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This item was presented at the Board's March 12, 2020 special meeting. The Board directed staff to obtain additional information from the executive search firms and return the item to the Board at the April 2, 2020 meeting.

At the Board's April 2, 2020 meeting, staff presented this item again along with the responses to the questions raised by Board members at the March 12, 2020 meeting (summarized in the attached table). The Board directed staff to query the executive search firms on their willingness to: 1) waive fees if the Board ultimately appoints an internal or Board-referred candidate to the Chief Executive Officer position and 2) enter into a non-inclusive contract, allowing CalOptima to contract with more than one vendor to fill the position. Additionally, the Board directed staff to evaluate the request for information responses from the vendors and return to the Board in May with a recommendation on engaging executive search firm(s).

Three firms agreed to reduce their rates if the Board ultimately appoints the interim CEO to the permanent CEO position. If the Board names up to three candidates at the time of contract execution and later appoints one of those three candidates, the fourth firm, will waive the fees entirely; however those candidates would be excluded from participating in the recruitment process. Human Resources does not recommend excluding candidates from participating in the vendor's recruitment process as all candidates should be treated similarly. None of the firms expressed a willingness to enter into a non-inclusive/contingent contract.

Staff evaluated and rated the firms' based on the following criteria: experience, background, recruitment process, contracting (e.g. availability to start recruitment, absence of lawsuits, willingness to accept CalOptima contract template), and pricing with and without the carve-out provision.

VENDOR	Final Weighted Score
Korn Ferry International	11.80
Morgan Consulting	10.80
Spencer Stuart	11.80
Witt Kieffer	12.30

When considering the criteria above as well as the firms' willingness to waive or reduce fees should the Board appoint the interim CEO as the permanent CEO, staff ranked Witt Kieffer as the top firm; however, the 1/3 fee reduction is only valid if the Board appoints the interim CEO prior to 120 days after the contract is executed.

Spencer Stuart and Korn Ferry International tied in second place ranking; however, staff recommends Korn Ferry International over Spencer Stuart because, although Spencer Stuart will waive fees entirely to carve-out up to three Board named candidates, the firm will not allow Board named candidates to participate in the recruitment process. Korn Ferry International is willing to reduce fees by 1/2 (50%) if the Board appoints the interim CEO at any time during the recruitment.

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Because of this time restriction imposed by one of the firms, staff is proposing two options for the Board's consideration. Consistent with Board-approved purchasing policy, authorize staff to enter into a contract with:

- Option A - Witt Kieffer and include a carve out provision to reduce fees should the Board appoint the interim CEO as the permanent CEO prior to 120 days after contract execution; or
- Option B - Korn Ferry International and include a carve out provision to reduce fees should the Board appoint the interim CEO as the permanent CEO at any time during the recruitment.

Both recommended firms were founded in 1969 and have numerous offices internationally and locally. Both firms have worked with healthcare clients in Orange County. Of note, Witt Kieffer has worked with CalOptima in the past to recruit for CEO, Chief Finance Officer, Chief Information Officer, and Chief Operating Officer. More detailed information on all four firms is provided in the Vendor Comparison attachment.

Fiscal Impact

The recommended action to contract with an executive search vendor for CEO recruitment is budget neutral with no additional fiscal impact. An allocation of up to $250,000 from existing reserves approved by the Board on April 2, 2020, will fund this action.

Rationale for Recommendation

Finding suitable and qualified candidates for CalOptima's CEO position in this very competitive market will entail a nationwide search. Management believes that using an executive search firm is the most efficient way to conduct such a search and promises to be the most successful manner in which to recruit and retain a new CEO given CalOptima's past experience in recruiting executive officers. Staff ranked Witt Kieffer number one based upon an evaluation of experience, background, recruitment process, contracting ability, and reduction of fees for up to 119 days should the interim CEO be appointed to the permanent CEO position. Korn Ferry International ranked number two based on the same evaluation, though significantly, Korn Ferry has agreed to reduce fees without any time limit on the fee reduction.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Executive Search Firms Vendor Comparisons
2. Conflict List

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

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Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
	General Background:			
Year Founded	1969	1995	1956	1969
Services Offered	Talent Acquisition Organization Strategy, Assessment & Succession, Leadership Development, and Rewards & Benefits	Healthcare Executive Recruiting	Executive Search and Recruitment Board Services, CEO Succession Planning, Executive Assessment Services, Leadership Advisory Services	Executive Search Senior and Mid-Level Executive Search Interim Leadership, Board Services
Number of Offices and Location	103 offices in 50 Countries Local offices in LA, San Francisco and Irvine	All staff work virtually out of 7 cities	60 offices in 31 countries Local offices in Orange County, LA, San Francisco	20+ offices in 3 Countries Local Offices Irvine, San Francisco
Number of Employees	8,500+	10	2,200+	250+
	Past Experience:			
References	Confidential	Community Health Center of Snohomish County (CEO) IEHP (CMO/CFO)	Confidential	IEHP Partnership Health Plan of CA
Orange County Clients	CHOC Hoag UCI	American Addiction Centers MemorialCare Health System	Confidential	CHOC Hoag Memorical Care Mission Hospital Providence Share Our Selves UCI
Client(s) most similar to CalOptima	Affinity HP AHIP AltaMed Health First Molina	Alameda Alliance for Health Community Health Group Gold Cost Health Plan of San Joaquin Health Plan of San Mateo IEHP LA Care	Confidential	AlohaCare CareOregon Community Healthplan of Washington Gold Coast Healthplan IEHP Partnership HP of CA Santa Clara Family Healthplan San Francisco Healthplan
Direct CalOptima Experience	None Provided	No Previous Experience	No Previous Experience	CalOptima COO, CIO, CFO, CEO
Recruiter Resumes	Brian Joyce Principal for Health Insurance Practice. 21 years experience, 18 in HealthCare. Stamford CT. Jessica Johnson Principal for Healthcare Services, 13 years with Korn Ferry, with experience in Providers, Payors, and others, Irvine, CA	Paula Morgan 20+ years in Healthcare Recruiting Rosie Saenz 20+ years in health benefits, managed care and workers comp Lu Miller 20+ years in multiple Health insurance product Lisa Coyne 15+ years experience Donna Hulse, Alex Drury, Lynn Barboza and Kim Phillips round out the team with other experience in Recruitment, Healthcare and insurance. Lynn or Lisa will be assigned to CalOptima.	Dieter Freer 25+ years of experience in global heathcare and insurance practices. Experienced in Payor segment in both profit and non-profit. Past regional president of Cigna, and served at both BCBS of NJ and NY. Kristine Johnson Sr Leader in the firms nonprofit and Gov't Practice, experience in recruiting and CEP succession planning and Board transitions. Past, Director of executive recruitment for Disney.	Mark Andrew 20+ years experience at Witt Kieffer, experience with Providers, Payers, in Gov't and public health. Previously, Mark was founding partner and chief executive officer of a medical search in California, where he recruited execs and physicians in several medical disciplines. Christopher Neumann also has over 10+ years experience, with focus in hospitals, health systems and MCO's.

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Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
Prior/Recent Placements	CEO - Affinity, AHIP, Beacon, BCBS of AZ, LA , MN and NC, Care First, Care Source, Emblem, Health First, Humana, Molina, MVP Health Care, and others	CEO - SeniorSelect Partners, Wyoming eHealth Partnership, Care Wisconsin, Cal eConnect, Hospitality Health, Health Share of Oregon, Alameda Alliance, Missouri HIO,. Many COO's, CFO's and CMOs for similar organizations.	Confidential	CEO - IEHP, Partnership HP of CA, Santa Clara Family HP, Gold Coast HP, San Francisco HP, CareOregon, AlohaCare, Community HP of Washington.
Success Rates ***Note: retained firms are paid under a non-contingent format (paid regardless if they fill the position or not)***	Not Provided	100% for CEO Placements	Not Provided	Last 3 years, 97%.
	Recruitment Process:			
Timeline / Activities	Define Requirements with CalOptima Use Korn Ferry Four Dimensional Executive Assessment (KF4D) Build strong candidate pool Screen candidates Arrive at short list Aassess finalists Hold behavioral interviews Receive executive feedback Approx 16 weeks	Intake and site visit Develop marketing material Ffinalizing the position description Marketing the position Initial slate of candidates Ongoing slate of candidates Interviews Offer Follow-up Average 16.2 weeks	Framing the need with CO leadership and stakeholders Preliminary Research Trageted outreach and development, thorough assessment of candidates, customized interview process, strong closing between offer and onboarding. Approx 20 weeks	Discovery Phase Development of Leadership Profile and Recruitment Strategy Recruitment and Candidate Evaluation, Candidate Review Semi-Finalists Interviews Finalist Interviews Selection and Negotiations Approx 19-20 weeks
	Contracting:			
Contract Changes	10-15 Changes (mostly minor)	5 Changes (minor)	25+ Changes (minor to moderate)	5-10 changes (minor)
If Awarded, Can they start immediately	YES	YES	YES	YES
Current Disputes/Litigation	None	None	We enter into routine litigation over receivables in the ordinary course of business which do not typically exceed $500,000.	None
Current Governmental Investigations	None	None	None	None
Inquiry Letters / Negative Audit Results	None	None	None	None
Use of any subcontractors	None	None	None	None
	Price:			
Other Candidate Sources	As a retained search firm, Korn Ferry would equally process an internal candidate like any external candidate. They would take any referrals through our website/ positing/ or internal referrals and process them as we would any external candidate identified by Korn Ferry.	Candidates who surface from all sources including internal candidates will be referred to MCR for screening and will be considered MCR candidates.	N/A	Candidates who surface from all sources including internal candidates will be referred to Witt Kieffer for screening and will be considered Witt Kieffer candidates.
Guarantee Language	12 month guarantee from the selected candidate's start date; if the candidate resigns or is terminated Korn Ferry will conduct a new search at no additional fee, only billing direct expenses as incurred	MCR agrees to conduct a replacement search for no additional search fee if the candidate placed by MCR should leave or is terminated for cause within twelve months of employment.	12 month guarantee if discharged or resigns at no cost, other than direct costs as before.	12 month guarantee if discharged or resigns at no cost, other than direct costs as before.
Ability to Enter into Non-Inclusivity Agreement	No	No	No	No
Ability to Carve Out Board-Referred Candidate	Yes - interim CEO only. No time limit on Board appointing CEO to receive reduced fee.	Yes - interim CEO only. Board must appoint CEO within 30 days from presentation of candidates to the Board to receive reduced fee.	Yes - interim CEO or other Board considered candidates at time of contract execution (up to 3), but will not process candidate(s) through the recruitment process. No time limit on when Board must appoint CEO to receive waiver of fees (minus direct costs already incurred).	Yes - interim CEO only. Board must appoint CEO within 120 days of contract execution to receive reduced fees.

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Executive Search Firms

	Korn Ferry	Morgan	Spencer Stuart	Witt Kieffer
Carve Out Pricing	Price is reduced by approximately 1/2 (minimum retainer of $90,000), excluding direct costs.	Price is reduced 1/3, excluding direct costs.	Fees are waived, except direct costs already incurred.	Price is reduced 1/3, excluding direct costs.

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CONFLICT LIST FOR THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Korn Ferry International	2600 Michelson Dr., Ste. 720	Irvine	CA	92614
Morgan Consulting Resources, Inc.	7923 Geary Blvd.	San Francisco	CA	94121
Spencer Stuart	2020 Main Street, Suite 350	Irvine	CA	92614
Witt Kieffer	2015 Spring Road, Suite 510	Oak Brook	IL	60523

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Recommendations Related to Previously-Approved Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

Contact
Candice Gomez, Executive Director, Program Implementation, 714-246-8400

Recommended Actions
1. Authorize CalOptima to provide organizers of community events that have been cancelled or postponed due to the COVID-19 pandemic the option of either refunding CalOptima's prepayments or, alternatively, applying CalOptima's prepayments to one or more future event(s) provided that the events:
    a. Occur on or before June 30, 2021;
    b. Meet the eligibility criteria described in Policy AA.1223 ~~1123~~: Participation in Community Events by External Entities, and
    c. Are approved for CalOptima's participation by CalOptima's Chief Executive Officer (CEO).
2. Make a finding that application of prepayments to one or more future event(s) meeting these criteria are for an acceptable public purpose in support of CalOptima's community partners during the COVID-19 pandemic and are in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the CEO, with the assistance of Legal Counsel, to execute agreements as necessary for CalOptima's participation in the future events.

Rev. 5/7/20

Background/Discussion
On January 31, 2020, the Secretary of U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. The Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social and community gatherings outside of a list of "essential activities." As a result, CalOptima is not attending any-in person community events, health and resource fairs, town halls, workshops, and 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.

The CalOptima Board of Directors (Board) approved expenditures in support of CalOptima's participation in the following community events that have been cancelled or postponed due to stay-at-home orders:

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- On December 5, 2019, the Board approved up to $5,000 financial participation in the Family Choices of California 2020 Annual Health Summit and Legislative Day on March 15–17, 2020, which has now been postponed to October 4–6, 2020;
- On February 6, 2020, the Board approved up to $2,000 in financial and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival on March 22, 2020, which was cancelled;
- On March 5, 2020, the Board approved up to $2,000 in financial and staff participation at the Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event on April 5, 2020, which was cancelled;
- On March 5, 2020, the Board approved up to $2,000 in financial and staff participation at the Arts Orange County 8th Annual Dia del Nino Festival on April 18 and 19, 2020, which was cancelled; and
- On March 5, 2020, the Board approved up to $2,500 financial and staff participation at the Kid Healthy 9th Annual Cooking Up Change–Greater Orange County Event in Santa Ana on April 23, 2020, which has been postponed to a future date not yet determined.

CalOptima recognizes the unprecedented health and economic challenges our community, community partners and members are experiencing due to the COVID-19 pandemic. CalOptima has a strong history of supporting the community's most vulnerable populations and collaborating with community partners, providers and key stakeholders to meet the needs of the community and will continue to do so consistent with federal, state and local guidance. As such, staff recommends providing event organizers the option to refund previously pre-paid participation fees or apply fees to one or more future event(s) provided that such future event(s) are approved by CalOptima's CEO, meet the criteria set forth in Policy AA.1223 ~~1123~~ Participation in Community Events by External Entities, and are held on or before June 30, 2021. *Rev. 5/7/20*

In making these recommendations, staff has considered the immediate financial burden many of our community partners are experiencing, their primary focus on serving our members and others in the community, as well as CalOptima's relationships with the agencies and their history of hosting similar events in the past. Staff understands that there may be a risk in this approach as the community organization may not host a future event or the community organization may not be in operation to host a future event. Staff is making these recommendations in support of the community organizations despite the potential risks.

Fiscal Impact
There is no additional fiscal impact to the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation
Staff recommends approval of the recommended actions in response to the COVID-19 pandemic in order to continue to support community partners and provider activities that offer opportunities that reflect CalOptima's mission. Any refunds received would be returned to CalOptima's reserves.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated December 5, 2019, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events
3. CalOptima Board Action dated February 6, 2020, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Event
4. CalOptima Board Action dated March 5, 2020, Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

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Attachment 1 to May 7, 2020 Board of Directors Meeting – Agenda Item 13

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Family Voices of California	1663 Mission St.	San Francisco	CA	94103
Iranian American Community Group	6789 Quail Hill Pkwy.	Irvine	CA	92603
Access California Services	631 S Brookhurst St., Suite #107	Anaheim	CA	92804
Second Baptist Church	4300 Westminster Ave.	Santa Ana	CA	92703
The Arts Orange County	17620 Fitch, Suite #255	Irvine	CA	92614
Kid Healthy	1901 E 4th St., Suite #100	Santa Ana	CA	92705

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
18 Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize expenditures for CalOptima's participation in the following community events:
    a. Up to $10,000 and staff participation at the Vietnamese Community of Southern California (VNCSC) 2019 Year of the Rat Tet Festival in Fountain Valley on January 25-26, 2020;
    b. Up to $10,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Tet Festival Year of the Rat in Costa Mesa on January 25-26, 2020; and
    c. Up to $5,000 for CalOptima's participation in the Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day on March 15-17, 2020 in Sacramento;
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 events 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 marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion
The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen relationships with our community partners.

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a. **Vietnamese Community of Southern California (VNCSC) 2020 Year of the Rat Tet Festival in Fountain Valley**.
Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Fountain Valley. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for six years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: One (1) 20x20 exhibitor booth in a prime location, two, three (3) 3' x 8' banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, fifteen (15) television impressions, and full ad on ten thousand (10,000) fliers distributed throughout the OC and two (2) 8'x 8' back drop on Tet Festival stage. The event organizer anticipates more than 20,000 visitors throughout the day. This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about all CalOptima's programs and services with this under-served and hard to reach population.

b. **The Union of Vietnamese Student Associations Southern California (UVSA) 39th Annual Year of the Rat Tet Festival in Costa Mesa.** Staff recommends the authorization of expenditures for participation in the Lunar New Year Tet Festival scheduled in Costa Mesa. This event celebrates the new lunar year and preserves the Vietnamese culture and traditions with the surrounding community. The event will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees and share information about CalOptima's programs and services. Vietnamese members comprise approximately eleven percent of CalOptima's total membership. CalOptima has participated in this event for thirteen years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: Five (5) minute speaking opportunity, one (1) 20x 20 exhibitor booth in a prime location, twenty (20) admission tickets, two (2) three day admission badges, one (1) banner display near the main entrance, logo link on event website for one (1) year, full page program color ad, pageant program full page ad, Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services.

c. **Family Voices of California (FVCA) 2020 Annual Health Summit and Legislative Day in Sacramento.** Staff recommends the authorization of expenditures for participation in FVCA's Annual Health Summit and Legislative Day scheduled in Sacramento. FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with DHCS and the Legislature on the Whole-Child Model program. Specifically, FVCA has

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reached out to Medi-Cal managed care plans, including CalOptima, to support Orange County children and families during the California Children's Services transition to the Whole-Child Model. CalOptima has participated in this event for three years. Staff recommends CalOptima's continued support for this event with a $5,000 financial commitment for 2020, which includes the following: Verbal recognition at the Summit, CalOptima logo on the Summit materials and social media, one (1) CalOptima branded item in attendee packets and Summit attendance for two (2) representatives.

CalOptima staff has reviewed the request and it meets the consideration 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 staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be 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 $25,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Board Action
2. Vietnamese Community of Southern California Sponsorship Request Letter
3. Union of Vietnamese Student Associations of So. California 2020 Tet Sponsorship Package
4. Family Voices of California 2020 Annual Health Summit Sponsorship Package

/s/ Michael Schrader — *11/26/2019*

Authorized Signature — **Date**

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Attachment to the December 5, 2019 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Vietnamese Community of Southern California	P.O. Box 457	Garden Grove	CA	92842-2316
Union of Vietnamese Student Associations of Southern California	P.O. Box 2069	Westminster	CA	92684
Family Voices of California	300 J. Street	Sacramento	CA	95814

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VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
Domestic Non-Profit Corporation C1479500 • EIN 33-0448822 • Founded 1990
P.O. Box 457 • Garden Grove, CA 92842-2316
Email: contact@vncsc.org • Website: www.vncsc.org
Tel: (714) 248-6191

November 6th 2019

Dear Cal Optima,

We are writing you this letter concerning a sponsorship opportunity to celebrate the upcoming Lunar New Year 2020, the Year of the Rat.

Vietnamese Community of Southern California (VNCSC) has the honor of being selected to work with County of Orange and OC Park for the celebration of the 2020 OC Tet Festival at Mile Square Regional Park in Fountain Valley, from January 24th to January 26th 2020. This 3-day special event is free admission and open to public.

This is the fourth annual Tet Festival held at Mile Square Park, which, in past years, had attracted more than eighty thousands of Southern Californians and out-of-state visitors. This is a cost-effective opportunity to promote your business, and we would like to invite you to become one of our Major Gold Sponsors as last year.

A $10,000.00 sponsorship packages will provide you:
> 20' x 20' booth in prime location at the Tet Festival Mile Square Park
> Three (3) 3' x 8' banner displays
> Twenty (20) mentions on stage
> Twenty-five (25) radio impressions
> Fifteen (15) television impressions
> Full ad size 5.5 x 8 inches (the other side will be Tet Festival announcement) on ten thousand (10,000) flyers distributed throughout Orange County prior to the event.
> Two (2) 8' x8'back drop on Tet Festival Stage.

For almost 30 years, the VNCSC has been a strong and influential voice for Little Saigon, the largest and most established community of Vietnamese expatriates in the world. With the collaboration of other non-profit organizations, we have provided resources to help our many members of the community at large and to preserve the Vietnamese Culture and Heritage.

The name and reputation of your business will not only be remembered by our patrons who came to the event, but also be known by their relatives and friends at home, too. The exposure of your company therefore would be significant and we cordially invite you to join our activities in order to reach out one of the most vibrant Vietnamese American Communities of the world and becomes a prestigious sponsor for the Vietnamese Cultural Village in this special event.

Your contribution can definitely make a difference and we are looking forward to building a successful partnership with your company. All any additional information, please feel free to contact us at:

Vietnamese Community of Southern California (VNCSC)
P.O. BOX 457, Garden Grove, CA 92842
Phone number: (714) 248-6191, Email: vncsc1990@gmail.com

Sincerely,

Hoa Nguyen

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TẾT

FESTIVAL
SPONSORSHIP PROPOSAL

JANUARY 24-26, 2020
OC FAIR & EVENT CENTER

Celebrating the Year of the Rat

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DEAR PROSPECTIVE SPONSOR,

The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to our diverse audience.

The 39th Annual UVSA Tết Festival will take place between January 24 to 26, 2020 at OC Fair & Event Center — adjacent to Costa Mesa, Newport Beach, Santa Ana, and Irvine. The event attracts upwards to 50,000 guests, encompassing a multi-ethnic populace with strong Asian American presence.

The event is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- UVSA has hosted the largest Tết Festival in the nation with 38 continuous years of success
- UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California
- We are the strongest Vietnamese youth organization in the country and we represent students and young professionals in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties
- Our involvement in the community is built upon cultural awareness, education, and social and civic engagement
- We provide leadership opportunities to over 300 volunteers
- UVSA is a 501(c)(3) charitable organization and has awarded over $1,500,000 in festival proceeds to deserving non-profit organizations across Southern California

We cordially invite your team to join us this year in making UVSA Tết Festival the most spectacular yet! We look forward to building a partnership with you as we welcome the Year of the Rat with prosperity and success for all. Thank you for your consideration.

Sincerely,

Nguyen D. Nguyen
President
president@uvsa.org

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FESTIVAL SUMMARY

EVENT
39th Annual UVSA Tết Festival

DESCRIPTION
Tết is a celebration of the Lunar New Year, the most observed holiday for Vietnamese people

OBJECTIVES
1. To celebrate the new lunar year
2. To preserve and promote Vietnamese culture & traditions with the surrounding community
3. To provide opportunities for local businesses to promote their products and services
4. To raise funds to support educational and cultural programs in the community
5. To bring Vietnamese youths together and provide them with opportunities for leadership development and community service

DATES
Friday, January 24, 2020; 4PM - 10PM
Saturday, January 25, 2020; 11AM - 10PM
Sunday, January 26, 2020; 11AM - 9PM

LOCATION
OC Fair & Event Center
88 Fair Dr., Costa Mesa, CA 92626

ATTENDANCE
50,000+ guests

Lion dancers performing at the Saturday Opening Ceremony

ATTRACTIONS
Carnival games and rides
Three stages, each offering a variety of programming for all ages
Vietnamese cultural village with over 30,000 sq feet of exhibits and structures
Exhibit hall with over 100 unique vendors

PROGRAMS

Miss Vietnam Pageant	Opening Ceremony	Children's Contests
Pho Eating Contests	Talent Show	Dance Competition
Live Music & Karaoke	Youth Night	Grand Concert
Gaming Tournaments	Cultural Performances	Influencer Meet & Greet

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HOSTING ORGANIZATION

ABOUT The Union of Vietnamese Student Associations of Southern California (UVSA) is a 501(c)(3) non-profit, non-partisan, community-based organization founded in 1982 consisting of students, alumni, young professionals, and community leaders. Our mission is to bring together Vietnamese American students and young professionals across Southern California to build unity, to serve the community, and to advocate for social justice issues that affect our community domestically and in Vietnam.

GRANTS Each year, half of net profits from the event are allocated towards the Tết Community Assistance Fund. Over the past 15 years, UVSA has awarded over $1.5 million to help Southern California non-profit organizations initiate community enrichment programs.

MEMBERS UVSA was founded on volunteerism and continues to be a 100% volunteer-based organization. With over 50 year-round staff, 300 project staff, and 500 day-of volunteers, UVSA strives to equip each volunteer with skillsets that will help them excel in their professional careers. Additionally, UVSA partners with local, self-governing Vietnamese student associations from the following universities:

- Chapman
- Cal Poly Pomona
- CSU Fullerton
- CSU Long Beach
- CSU Northridge
- San Diego State
- UC Irvine
- UC Riverside
- UC Santa Barbara
- UC San Diego
- University of Southern California

DEMOGRAPHICS & STATISTICS

According to the 2018 U.S. Census, 1,548,449 people identify as Vietnamese, ranking them fourth among the Asian American groups; 447,032 (40%) of them live in California. The largest Vietnamese population outside of Vietnam is found in Southern California—totaling over 300,000 members from Los Angeles, Orange, and San Diego counties. Vietnamese American businesses continue to grow in areas such as Garden Grove and Westminster while rapidly extending lucrative development to surrounding cities.

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KEY BENEFITS

The success of this event depends on the generosity of sponsors. In return, UVSA aims to provide sponsor with the following benefits:

- Brand awareness and brand loyalty from current and prospective buyers
- High-level media exposure from local television stations, radio stations, magazines, newspapers, and advertisements
- Large-scale onsite product promotion and face-to-face customer interaction
- Positive public outreach and market response
- Recognition as an industry leader above competitors

Toyota showcases their latest vehicles in a custom 30' x 40' booth

The Miss Vietnam of Southern California Royal Court pose for Lexor's custom 20' x 10' booth

The Miss Vietnam of Southern California Royal Court pose for Sunpower's 20' x 20' booth

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SPONSOR PACKAGES

We offer the following sample packages which include standard benefits. However, we prefer to create for you a custom package designed to best connect your business to our audience. We hope that you take this opportunity to sponsor the event as a means to promote brand loyalty from a very accomplished community.

	SPONSOR BENEFITS	MEDIA OR IN-KIND TRADE (varies with value)	BRONZE $3,500	SILVER $6,000	GOLD $12,000	DIAMOND $20,000	TITLE $35,500
PRE-EVENT	Logo and link on event website for 1 year	✓	✓	✓	✓	✓	✓
	Social media post				✓	✓	✓
	Logo on event ad in Vietnamese newspapers					✓	✓
	Logo on all promotional materials						✓
	Logo on online admission tickets						✓
	Logo on event billboard in Garden Grove						✓
ON-SITE	Booth in prime location	10' x 10'	10' x 10'	10' x 20'	20' x 20'	20' x 30'	20' x 40'
	Admission tickets	30	10	20	40	90	150
	3-day admission badges	1	1	2	4	8	10
	3-day parking hang tags	1	1	2	4	8	10
	Banner display near main entrance	1	1	1	1	1	1
	Banner display near exit				1	6	1
	Banner display near main stage				1	2	4
	Graphic ad on main stage				3 runs / day	5 runs / day	5 runs / day
	Color ad on in event program book				half page	full page	back cover
	Logo on back of 500 volunteer t-shirts					✓	✓
	Logo on event directory					✓	✓
	30-second video ad on Main Stage						2 runs / day
	Speech at opening ceremony						5 minutes
	Speech at pageant with check presentation						5 minutes
	Sponsor mentions on PA system looped inside event entrance area						✓
	Logo on back of all admission tickets						✓

A LA CARTE BENEFITS

Admission Tickets — $6 ea
Admission Badges — $30 ea
Parking Hangtags (3-day) — $30 ea
Logo link on event website for 1 year — $500
Banner ad link on event website for 1 year — $750
Logo on back of 500 volunteer t-shirts — $500
Logo on event ad in newspapers — $1,000
Social media post — $250
Logo display on ticket booth windows — $400
Banner display (stage, gates, food court) — $500

On-site event activation with booth:
- 10' x 10' — $3,000
- 10' x 20' — $5,000
- 20' x 20' — $8,000
- 20' x 30' — $12,000
- 20' x 40' — $16,000

Program Book Ads (30,000 prints)
- Half-page color — $1,000
- Full page color — $1,500

Speaking opportunities — $1,000 (5 min)

Main Stage LED Screen Ads
- Graphic — $100 (1 run / day)
- 30-second video — $500 (1 run / day)

Presenting Sponsor for Programs:
- Pho Eating Contest — $1,500
- Children's Pageant — $1,500
- Talent Show — $1,500
- Youth Night — $3,000
- Grand Concert — $3,000

Pageant program full page ad — $1,000

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PLEDGE FORM

COMPANY NAME: _____

CONTACT NAME: _____ TITLE: _____

PHONE: ( ) _____ EMAIL: _____

SPONSORSHIP PACKAGE

- ☐ BRONZE ($3,500)
- ☐ SILVER ($6,000)
- ☐ GOLD ($12,000)
- ☐ DIAMOND ($20,000)
- ☐ TITLE ($35,500)
- ☐ MEDIA TRADE valued at: $ _____
- ☐ IN-KIND TRADE valued at: $ _____
- ☐ CUSTOM PACKAGE: $ _____
- ☐ DONATION ONLY: $ _____

PLEASE DESCRIBE ANY REQUESTS FOR YOUR SPONSORSHIP: _____

PLEASE DESCRIBE YOUR SERVICES: _____

_____ _____

SIGNATURE DATE

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UNION OF VIETNAMESE STUDENT ASSOCIATIONS OF SOUTHERN CALIFORNIA

"DEVELOPING THE NEXT GENERATION OF LEADERS"

CONTACT US

Tel: (714) 388-6711
Email: tet.sponsorship@uvsa.org

MAIL
PO BOX 2069
WESTMINSTER, CA 92684

WEBSITE
WWW.UVSA.ORG | WWW.TETFESTIVAL.ORG

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FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care
d

Alpha Resource Center of Santa Barbara
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
(805) 683-2145
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Ave.
Suite 6050, Unit 35
Alhambra, CA 91803
(626) 300-9171
info@elafrc.org

Family Resource Navigators
291 Estudillo Ave
San Leandro, CA 94577
(510) 547-7322
eileenc@frnoakland.org

Support for Families of Children with Disabilities
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494
info@supportforfamilies.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street,
Suite 700
San Francisco, CA 94103
(415) 282-7494

info@familyvoicesofca.org
www.familyvoicesofca.org

October 22, 2019

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima

Re: Sponsorship Request for Family Voices of CA 2020 Health Summit

Dear Tiffany:

Family Voices of California (FVCA) provides families of children and youth with special health care needs (CYSHCN) with information, tools, and support to advocate for better access to high quality care. We build partnerships, inform stakeholders, and foster parent engagement to give families a voice in healthcare policy making.

We would like to request sponsorship from CalOPtima for our 2020 Annual Health Summit and Legislative Day, which will be held on March 15-17, 2020 in Sacramento so that we may continue to advance these efforts. CalOPtima's sponsorship would specifically support family members from Orange County who are in the Whole Child Model program to attend the Summit. The funds will cover their travel, lodging, meals and a stipend for the 2 ½ days of meetings.

Advocates, health care providers and professionals, government representatives, and legislators and staff will join parents and caregivers for updates on health policy issues facing CYSHCN. Speakers will provide policy and program updates, and families will share perspectives on the impact of policies on their lives. The Summit will be followed by legislative meetings at the State Capitol, where families will educate lawmakers about the issues they face and put a personal face on the impact of legislation and budget decisions.

With your sponsorship we can make our 2020 Summit a great success by:

- Educating and informing parents and decision makers about critical issues facing CYSHCN.
- Building collaboration among families, legislators, regulators, providers, and community based organizations to increase parent involvement at all levels of community and government health policy making.
- Engaging parents in policymaking through legislative meetings.

Nearly 100% of those attending our 2019 Summit agreed that the support, information, and resources they received helped them feel more confident about getting their child the health care and services they need; and as a result they took action during Legislative Day and beyond. With your support FVCA can continue our work to advance public policies and system improvements that will help families of CYSHCN access the care they need.

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Please see the attached menu of sponsorship activities, and don't hesitate to contact me for more information at pipmarks@familyvoicesofca.org or 415-282-7494 ext. 123.

Thank you for your consideration of this request!

Sincerely,

Pip Marks
Project Director

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FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please return your completed form to Pip Marks at pipmarks@familyvoicesofca.org or 1663 Mission Street, Suite 700, San Francisco, CA 94103

☐ **Leadership – $10,000**

A speaking role at the Summit
Verbal recognition at the Summit
Prominently placed logo on Summit materials
Inclusion of 1 item in attendee packets
Inclusion in social media marketing
Summit attendance for 3 representatives

☐ **Spirit – $5,000**

Verbal recognition at the Summit
Logo on Summit materials
Inclusion in social media marketing
Inclusion of 1 item in attendee packets
Summit attendance for 2 representatives

☐ **Partner – $2,500**

Verbal recognition at the Summit
Logo on Summit materials
Summit attendance for 1 representative

☐ **Collaboration – $1,500**

Verbal recognition at the Summit
Listing in Summit materials
Summit attendance for 1 representative

☐ **Hope – $800 x _____ = $ _____** **(**Sponsor a family member to attend the Summit)

Listing in Summit materials

Sponsor a parent/caregiver of a child with special health care needs to attend the Summit. Each family sponsorship provides travel, lodging, and childcare.

☐ **Other – Donation**

Amount:

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FAMILY VOICES of California

2020 Health Summit Sponsorship Commitment

March 15-17, 2020
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please make checks payable to:
Support for Families of Children with Disabilities
and reference/memo Family Voices of California

Please return your completed form and send to:

Pip Marks at pipmarks@familyvoicesofca.org
or
1663 Mission Street, Suite 700, San Francisco, CA 94103

Name: _____

Organization/Company: _____

Address: _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Thank you for your support of families of children and youth with special health care needs!

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Event

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize expenditure for CalOptima's participation in the following community event:
    a. Up to $2,000 and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival in Irvine on March 22, 2020;
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 marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended event will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

a. **Iranian American Community Group's 7th Annual Persian Nowruz Festival.** Staff recommends the authorization of expenditures for participation in the Iranian American Community Group's 7th Annual Persian Nowruz Festival. This is an educational event celebrating the Persian New Year that highlights the culture and traditions of the Persian community. The event will include cultural performances, traditional foods and resource

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tables. This event provides an opportunity to share information about CalOptima's programs and services with our members who speak Farsi, which is one of CalOptima's threshold languages. A $2,000 financial commitment for the Iranian American Community Group's 7th Annual Nowruz Festival includes: CalOptima's name and logo on recognition banner, event program and announcement on main stage, one (1) resource booth and invitation to VIP tent at the event. The event draws nearly 4,500 annually from the Persian community, Persian organizations and their members and Iranian-American community leaders. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Farsi and share information about CalOptima's programs and services.

CalOptima staff has 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 staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be 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 $2,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support a community activity that offers an opportunity that is in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

1. Entities Covered by this Recommended Board Action
2. Nowruz 2020 Sponsorship Package

/s/ Michael Schrader *01/28/2020*

Authorized Signature **Date**

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Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 18

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Iranian American Community Group of Orange County	6789 Quail Hill Pkwy, Ste. 626	Irvine	CA	92603

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Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Dear Nowruz Sponsor:

On behalf of Nowruz 2020 Iranian American Community Group (IACG) Festival Committee, I am pleased to invite you to join our circle of sponsors to support this exciting cultural event.

On Sunday, **March 22, 2020, from 1-6 pm,** the Persian community will celebrate the **7th Annual Persian Nowruz Festival (Eid)** at the Rose Garden at Bill Barber Community Park (next to Irvine's city hall), in Irvine, California.

For thousands of years Iranians have celebrated Nowruz as the beginning of the year. The colorful celebration of Nowruz marks the beginning of spring and Persian New Year, which is a time to begin a new life, and the first day of spring.

Since 2014, volunteers from several supporting non-profit organizations gather annually to create an extraordinary event to showcase the rich Persian culture. This fun event includes free entrance to the festival, music, dance, children's activities, Persian cuisine, and much more. The number of participants has grown steadily over the years to nearly 4,500 annually. This year we expect that number to be even greater.

Sponsorship of Nowruz provides your business with a unique opportunity to reach thousands of Iranian-Americans living in Southern California. While engaging and inspiring, your participation will allow you to extend your loyalty to Persian culture among thousands of visitors to the festival.

The enclosed materials provide information on the levels of sponsorship and the benefits associated with each level. Please take this opportunity to become involved with the community while promoting Persian culture and your business to thousands of attendees.

We look forward to recognizing you as one of our major sponsors at Nowruz 2020. Please e-mail us at iacgroupoc@gmail.com with any questions you may have.

Best Regards,

Kamran Taghdiri, PhD, IAC Nowruz Executive Director & CFO
Nowruz Festival Committee

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsorship Levels

IAC Group is a 501 (c) (3) organization (**Tax ID #: 47-5363120**)

Your sponsorship is a valuable component of Nowruz celebration festival. Your support will help us to exhibit and represent diverse collection of traditional events and lively programs. It will also encourage children to learn about their rich heritage by participating in this cultural event.

PLATINUM Sponsor ($ 2,000 +)

- Name and logo display on a recognized banner at a recognized section at the event
- Name and logo display on recognized section of the program hand out to participants
- Announcement on main stage as platinum sponsor
- A table at the event for distributing company's information (no sales transactions)
- Invitation to VIP tent of the event

GOLD Sponsor ($ 1,000 +)

- Name display on banner at a recognized section at the event
- Name on gold sponsors section of the program hand out to participants
- A shared table with other gold sponsors to hand out company's information (no sales transactions)

SILVER Sponsor ($ 500 +)

- Name display on banner at the event
- Name on silver sponsors section of the program hand out to participants

Friends of Nowruz ($ 100 +)

- Name on Friends of Nowruz section of program hand out to participants

IAC Group
Iranian American Community Group

Nowruz 2020
Persian New Year Celebration

March 22, 2020
Bill Barber Community Park, Irvine, CA

Sponsor Information

First Name: _____ Last Name: _____

Company/Organization: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____

Email: _____

Sponsorship Levels: (Please check options)

Description	Amount	Select
Platinum Sponsor	$ 2,000+	
Gold Sponsor	$ 1,000+	
Silver Sponsor	$ 500+	
Nowruz Friends	$ 100+	

Check: Check #_____ Bank Name_____

Sponsor Signature: ……. **Date:** ……...

Please Mail to: **Nowruz 2020 Celebration**
IAC Group
6789 Quail Hill Pkwy, Suite 626
Irvine, CA 92603

(Tax ID #: 47-5363120)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize expenditure for CalOptima's participation in the following community events:
    a. Up to $2,000 and staff participation at Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event in Santa Ana on April 5, 2020;
    b. Up to $2,000 and staff participation at the Arts Orange County's 8th Annual Dia del Nino Festival on Saturday and Sunday, April 18 and 19, 2020;
    c. Up to $2,500 and staff participation at Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event in Santa Ana on April 23, 2020; and
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 events 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 marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

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a. **Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event.** Staff recommends the authorization of expenditures for participation in Access California Services' Family Wellness Event. This is an educational event with a focus on mental health to address behavioral health challenges, stigma, cultural barriers, acculturation, and access to health/mental health services. CalOptima will have an opportunity to highlight behavioral health services available to our members. This event also provides an opportunity for CalOptima to interact with our members who speak the threshold languages of Arabic and Farsi and other attendees about our behavioral health services. A $2,000 financial commitment for Access California Services' 3rd Annual Peace of Mind Family Wellness Event includes: Opportunity for CalOptima leadership to share information about CalOptima's behavioral health services, CalOptima's name and logo on all marketing materials, one (1) resource booth and verbal recognition on the day of the event. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Arabic and Farsi and share information about CalOptima's programs and services.

b. **Arts Orange County's 8th Annual Dia del Nino Festival.** Staff recommends the authorization of expenditures for participation in the Arts Orange County's Annual Dia del Nino Festival. This is an educational event and resource fair with 30 interactive arts workshops and performances by professional guest artists and community artists to celebrate the richness and cultural heritage of Orange County's Latino community. This event attracts over 10,000 attendees and provides CalOptima an opportunity to share information about our programs and services with our Latino membership, which comprises approximately 45% of our total membership. Employee time will be used to participate in this event. A $2,000 financial commitment for the Arts Orange County's 8th Annual Dia del Nino Festival includes: One (1) resource booth, CalOptima's name and logo on event promotional materials and social media and invitation for CalOptima leadership to be recognized at the event.

c. **Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event.** Staff recommends the authorization of expenditures for participation in Kid Healthy's Cooking Up Change Greater Orange County Event. This event is a collaboration with school districts throughout Orange County to empower students to create and advocate for healthy school meals. Students from low-income schools are provided a platform to transform the school lunch menu using cost guidelines and high nutrition standards and to develop their leadership skills. Twelve high school teams from the cities of Anaheim, Santa Ana, Fullerton, Buena Park, Garden Grove, La Habra and Whittier compete in this event. This event provides CalOptima an opportunity to share information about our programs and services with our members. A $2,500 financial commitment for Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event includes: One (1) resource booth, CalOptima's name and logo on event signage, social media and video, complimentary event tickets for six, and invitation for VIP reception for two. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. This event also provides CalOptima an opportunity to strengthen our relationship with the school districts serving our members.

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CalOptima staff has 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 staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be 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 $6,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community activities that offer opportunities that are in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. Access California Peace of Mind Sponsorship Package
3. Arts Orange County Dia del Nino Festival Sponsorship Package
4. Kid Healthy Cooking Up Change Sponsorship Package

/s/ Michael Schrader *02/26/2020*
Authorized Signature **ate**

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Attachment 1 to the March 5, 2020 Board of Directors Meeting – Agenda Item 22

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Access California Services	631 S. Brookhurst St., Suite 107	Anaheim	CA	92804
Arts Orange County	17620 Fitch Ave., Suite 255	Irvine	CA	92614
Kid Healthy	1725 S. Douglass Rd.	Anaheim	CA	92806

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Arts Orange County's Día del Niño 2020

BRIEF DESCRIPTION OF PROJECT:

"Día del Niño," a free admission two-day festival, April 18-19, 2020, features daily 30 interactive arts workshops and performances by professional guest artists and community artists. It celebrates the artistic richness and cultural heritage of Orange County's multi-faceted Latino community through engaging arts experiences, connects residents to local arts organizations, provides them with access to new artistic disciplines, and fosters creativity and exploration among children and families of all backgrounds and heritages. Expected attendance: 10,000.

REQUEST AMOUNT: $10,000

TOTAL PROJECT BUDGET: $95,000

PRIMARY POPULATION: FAMILIES

NUMBER OF PEOPLE SERVED: 10,000

ORGANIZATION'S MISSION & VISION:

Arts Orange County's mission is to be the leader in building appreciation of, participation in, and support for the arts and arts education in Orange County, California. It aspires to play a key role in advancing the success of Orange County's creative community through excellence in its programs and services, advocacy

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Fern Street Circus at the 2018 and 2019 Dia del Ninos will again conduct workshops at the 2020 event.

efforts that result in increased private and public investment in arts and culture, community cultural planning, the expansion of art in public places, the full restoration of standards -based arts instruction in the public schools, equitable access to arts experiences countywide, and a thriving business community that embraces creativity and innovation. Governed by a diverse Board of Directors comprised of artists, leaders of arts organizations, the County Superintendent of Schools, leaders in higher education and business, and arts patrons, ArtsOC serves over 600 arts & culture organizations countywide. ArtsOC offers high quality core programs and services typical of local arts agencies that are supplemented with consulting services that are quite unusual for an organization of its type and serve an important local need.

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This painting workshop was popular at the 2018 and 2019 Dia del Ninos and is being offered again at this year's event.

WHAT RESULTS/IMPACT HAS YOUR ORGANIZATION ACHIEVED IN THE PAST THREE YEARS TOWARD MISSION?

ArtsOC has played a leading role in advocacy efforts at the local, state, and national level that have resulted in significant gains in the restoration of public funding for arts & culture that was decimated during the recession. This has brought tens of thousands of dollars in new and increased funding for arts organizations and for public schools in Orange County. With greater focus upon creative placemaking as a tool to help invigorate city life, ArtsOC has played a leading role in the installation of art in public places in Santa Ana, Costa Mesa, and Newport Beach as consultants and managers on contract with local government and nonprofit organizations. Additionally, ArtsOC has been at the forefront of programmatic innovation through being selected for pilot programs utilizing the arts for therapeutic purposes (our VOICES: Veterans Storytelling

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Crowds of all ages loved the performances by Relampago del Cielo at the 2018 and 2019 Dia del Nino.

Project), re-entry for offenders (Arts in OC Jail Project), and providing entry-level arts experiences for the underserved, as evidenced in the "Dia del Nino" Festival for which we are seeking Pacific Life Foundation support.

WHAT CHALLENGES HAS YOUR ORG FACED OVER PAST 3 YEARS AND HOW HAVE YOU MET THEM?

Nonprofit local arts agencies, like Arts Orange County, are at a competitive disadvantage in attracting support within the philanthropic marketplace--largely because the work they do is behind the scenes and in support of other arts organizations that have the natural attraction of constituencies through producing and presenting work. Additionally, a countywide organization like ours attempting to serve 34 cities, with their own identities and indigenous arts communities, has its work cut out for it to be effective. Probably the most effective tool in addressing these particular challenges has been ArtsOC's growing role as a cultural planner on contract with local municipalities. The planning process has created a by-product of building image and awareness of ArtsOC's mission and brand. Cultural planning work for Irvine, Mission Viejo, Newport

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Dance of the Jaguar performing at the 2019 Dia del Nino will return for 2020.

Beach and Costa Mesa has raised ArtsOC's profile considerably and connected it to new sources of support. Additional cities learn of ArtsOC's planning services directly or through their colleagues, and the demand shows signs of continuing to grow.

WHAT IS THE CHALLENGE OR OPPORTUNITY THIS PROJECT ADDRESSES?

The Latino community constitutes more than one-third of Orange County's overall population, there is limited representation of Latino arts and culture in the offerings of established organizations countywide, and a community "Dia del Nino" festival offered by another community arts organization was discontinued after a one-time presentation.

These led ArtsOC in 2012 to initiate its "Dia del Nino" festival, which will enter its ninth year in 2020. It was important to us from the beginning that the festival be authentic, be curated and presented in partnership with a local Latino community arts organization, that the event would go well beyond offering simply a passive

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Emily, a well-known Tejano singer will bring her sensational voice and smile to the 2020 Dia del Nino.

experience to attendees, and that each person who attends is directly engaged to participate and explore their own creativity in a variety of ways.

ANTICIPATED IMPACT OF PROJECT

"Dia del Nino" is designed to inspire lifelong learning and participation in the arts among 10,000 children and adults, to broaden the community's understanding of Latin-American arts & culture, to showcase talented student and amateur artists, to provide employment to outstanding professional teaching artists and world-class performing artists, and to introduce families to important local arts organizations, classes and agencies available throughout the county to continue their cultural exploration, enjoyment and artistic development.

KEY ELEMENTS OF THE PROJECT

To achieve the stated results, we will collaborate with a respected Latino community arts organization (Media Arts Santa Ana) together with which we will employ a curatorial approach that embraces presenting major national and regional Latin-American performers, including Grammy Award-winning recording

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Claudia de la Cruz is a nationally-known flamenco artist who will perform and teach at the festival.

artists, and the best local community artists and student talent from schools throughout Orange County.

All festival communications will be bilingual (English and Spanish) and the festival location will be fully accessible to those with disabilities. We will promote the event widely through the OC Department of Education, OC Public Libraries, shops and restaurants in Latino neighborhoods, a schedule of PSAs on KOCE-TV, the Los Angeles/Orange County flagship PBS station, and our media partner La Ranchera 96.7 FM, a popular Spanish-language Southern California radio station that reaches 420,000 listeners.

Throughout the days of the festival, there will be continuous performances on stage by such performing artists as the Latin Grammy Award-winning “kindie” band Lucky Diaz and the Family Jam Band (Día del Niño 2018), Grammy Award-nominated all-string Latin-American ensemble Trio Ellas (Día del Niño 2016-19), Latin Grammy nominee Ciro Hurtado, original and traditional Andean guitar music (Día del Niño 2014), Mariachi Divas, multiple Grammy Award-winning all-female mariachi band (Día del Niño 2016), Relámpago del Cielo Grupo Folklorico, a 40

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Student performers are part of the offerings at Dia del Nino.

year old professional traditional Mexican performing arts organization (Día del Niño 2012, 2018, 2019), Pacific Symphony String Quartet from Orange County's major orchestra (Día del Niño 2017), Moona Luna (Día del Niño 2018), Tejano singer Emily (Día del Niño 2018-19), Claudia de la Cruz Flamenco Dancers (Día del Niño 2018-19), and Fern Street Circus (Día del Niño 2018-19), among others.

Between performances, bi-lingual (English and Spanish) emcees will offer standup comedy, recite poetry, promote participating organizations and recognize the sponsors of the event—in 2018, Dyana Ortelli, the voice of Tia Victoria in the Academy Award winning Disney/Pixar film "Coco," emceed.

Ongoing workshops will offer instruction in a wide range of arts and crafts, including include flamenco, modern and hip-hop dance, clay flute making, papier-maché, drumming, beading, sketchbook making, poetry, video, theatre, painting, mosaics, puppetry, drum making, and circle painting.

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Workshops are offered in a wide variety of crafts: clay, fiber, and book-making are popular.

SUSTAINABILITY OF PROJECT

ArtsOC measures the event's success through the use of a face-to-face exit survey conducted in English and Spanish in order to determine if the festival experience would prompt attendees to pursue additional hands-on arts engagement throughout the year. ArtsOC will encourage featured local "Dia del Nino" festival workshop artists and performing artists to utilize their appearance in the festival as an opportunity to showcase their work to attendees as a means of encouraging continued participation--whether through ongoing classes they offer in the community or through private instruction. Exhibiting organizations at the festival also provide information about instructional programs they offer as well as opportunities for practitioners to hone their skills. Social media is used to continue the engagement and conversation with participants, leading up to the announcement of the following year's festival.

With respect to sustainable funding for "Dia del Nino," the festival has received seven consecutive years of funding from the National Endowment for the Arts

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Dia del Nino is a participatory experience for ALL ages!

and five consecutive years of funding from the Wells Fargo Foundation to support this program. While those are not guaranteed multi-year grants, our track record of success with those sources makes future grants more likely. Those grants are not alone sufficient to cover all of the costs, so additional funding from other sources is necessary and varies from year to year. But ArtsOC has thus far been successful in securing sufficient funds each year to sustain what has come to be regarded widely in the community as a worthwhile annual program.

CURRENT FUNDING FOR THE PROJECT:

National Endowment for the Arts - $25,000
California Arts Council - $15,000
The Crean Foundation - $15,000
The Lyons Share Foundation - $10,000
Pacific Life Foundation - $10,000
Wells Fargo Foundation - $5,000
OC Fair & Event Center - $5,000

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Cooking up Change®
NATIONAL

Join the Movement: Students Transforming the Future of School Food
Be a Lunch Hero: sponsor Cooking up Change® 2020 at the level indicated below (check one)

☐ **Super Hero: $20,000 or above:**

- Company Logo on ALL event print materials
- Recognition in social media campaign weekly
- Complimentary event tickets for 20
- Invitation for 10 to VIP Reception
- Company logo and hot link on event website
- Company representative to welcome attendees
- Company representative to present student awards
- Company representative interviewed in event video
- Company logo on chef jackets
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Power Partner: $15,000 or above:**

- Company logo on event print materials
- Company logo on event signage & video
- Recognition in social media campaign
- Complimentary event tickets for 15
- Invitation to VIP Reception for 8
- Company logo and hot link on event website
- Company representative to assist with awards presentation
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Awesome Ally: $10,000 or above**

- Company logo on event print materials
- Company logo on signage, social media campaign & video
- Complimentary event tickets for 10
- Invitation to VIP Reception for 6
- Company logo on website, photo booth props
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Super Side-Kick: $5,000 or above:**

- Company Logo on event print materials
- Recognition on event signage
- Recognition in social media & video
- Complimentary event tickets for 8
- Invitation to VIP Reception for 4

☐ **Marvelous Mate: $2,500 or above:**

- Complimentary event tickets for 6
- Invitation to VIP Reception for 2
- Recognition in social media & video
- Recognition in event signage

☐ **Amazing Associate: $1,000 or above:**

- Recognition in event signage
- Complimentary event tickets for 4
- Recognition in social media & video

☐ **Sensational Supporter: $300 or above:**
(non- profits & individuals only)

- Complimentary event tickets for 2
- Recognition in event signage

☐ **Friendly Force:**
Please accept my donation of $_____

Thank you for your support of Kid Healthy, please return this form:

Ma to:
K d Hea thy c/o OneOC
1901 E. Fourth Street, Su te 100 Santa Ana, CA 92705
nda@myk dhea thy.org

For Further nformat on Contact:
L nda Luna-Franks, Exec. D r.
949.874.7701
linda@mykidhealthy.org

kid HEALTHY

Charge my (circle one): Visa MasterCard American Express Check (Enclosed)

Amount $_____(Please make checks payable to Kid Healthy)

Name on Card:_____CardNo._____

Signature:_____Expiration Date:_____SecurityCode:_____

Company/Name:_____

Address:_____

Contact:_____Phone: _____Email:_____

Kid Healthy is a fiscally sponsored project of OneOC, a 501C3 not for profit Organization. All gifts are tax deductible as allowed by law.

Tax ID# 95-2021700

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AGENDA ITEM 14 *TO FOLLOW CLOSED SESSION*

Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2021 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Family Choice Medical Group	7631 Wyoming St., Suite 202	Westminster	CA	92683
AMVI/Prospect Health Network	600 City Parkway West Suite 800	Orange	CA	92868
Talbert Medical Group	2175 Park	El Segundo	CA	90245
Monarch Medical Group	11 Technology Drive	Irvine	CA	92618
Noble Mid-Orange County	17922 Fitch Avenue	Irvine	CA	92614
Arta Western Medical Group	2175 Park Place	El Segundo	CA	90245
UCMG	600 City Parkway West	Orange	CA	92868
AltaMed Health Services	2040 Camfield Ave	Los Angeles	CA	90040

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AGENDA ITEM 15 *TO FOLLOW CLOSED SESSION*

Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2021 and Execute Three-way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
HPN – Regal Medical Group/Dual Eligible	5810 Balboa Blvd., Suite 150	Northridge	CA	91325
Monarch Family HealthCare, OCC	11 Technology Dr	Irvine	CA	92618
Prospect Medical Group/Dual Eligible	1920 E 17th Street, Suite 200	Santa Ana	CA	92705
AMVI Care / Dual Eligible	1920 E 17th Street, Suite 200	Santa Ana	CA	92705
Talbert Physician Group/Dual Eligible	2175 Park Place	El Segundo	CA	90245
Noble Mid-Orange County/Dual Eligible	17922 Fitch Avenue	Irvine	CA	92614
Arta Western Medical Group/Dual Eligible	2175 Park Place	El Segundo	CA	90245
United Care Medical Group/Dual Eligible	600 City Parkway West	Orange	CA	92868
AltaMed Health Services/Dual Eligible	2040 Camfield Ave	Los Angeles	CA	90040
Family Choice Physician Group/Dual Eligible	7631 Wyoming St., Suite 202	Westminster	CA	92683

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Board of Directors Meeting
May 7, 2020

Special Joint Meeting of the Member Advisory Committee and Provider Advisory Committee Update

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April 9, 2020 Joint Meeting of the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC)

The MAC and the PAC held a special joint meeting on April 9, 2020 via Webinar and both committees achieved quorum. The committees welcomed Richard Sanchez, Interim Chief Executive Officer (CEO), and said farewell to Michael Schrader, the outgoing CEO.

Mr. Sanchez provided a CEO Report and told the Committees that the Federal and State Legislative update would be returning to the committees as per their recent request. He also reviewed several key legislative items with the committee members.

The MAC and PAC received a presentation on the Coronavirus (COVID-19) from David Ramirez, M.D., Chief Medical Officer. This presentation elicited many questions from members of both committees.

The MAC and PAC also received an informative presentation from PAC Chair, John Nishimoto, O.D., a practicing Optometrist, on the expansion of the scope of practice for Optometry.

Dr. Nishimoto also provided a PAC update for MAC members since the two committees are interested in doing more collaborative work.

The MAC and PAC appreciate the opportunity to update the Board on their current activities.

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A Public Agency

CalOptima

Better. Together.

Introduction to the FY 2020-21 CalOptima Budget

Board of Directors Meeting
May 7, 2020

Nancy Huang
Chief Financial Officer

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Overview

- Background
  - FY 2020-21 Budget Deliverables
  - Lines of Business
  - Provider Risk Arrangements
  - Operating Budget
  - Capital Budget
- Enrollment Projections by Program
- FY 2020-21 State Outlook
- FY 2020-21 Budget Considerations by Program
- Budget Process Timeline
- Board Approval Timeline

FY 2020-21 Budget Deliverables

- Operating Budget
  - Projected Income Statement
    - Attachment A: FY 2020-21 Budget for all Lines of Business
    - Attachment B: Administrative Budget Details by LOBs
- Capital Budget
  - Capital Budget by Categories
    - Attachment A: FY 2020-21 Capital Budget by Project

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 (MCE) and (3) Whole Child Model (WCM)
- MSSP program included under Medi-Cal. Beginning January 2021, MSSP will be carved-out of Medi-Cal

Provider Risk Arrangements

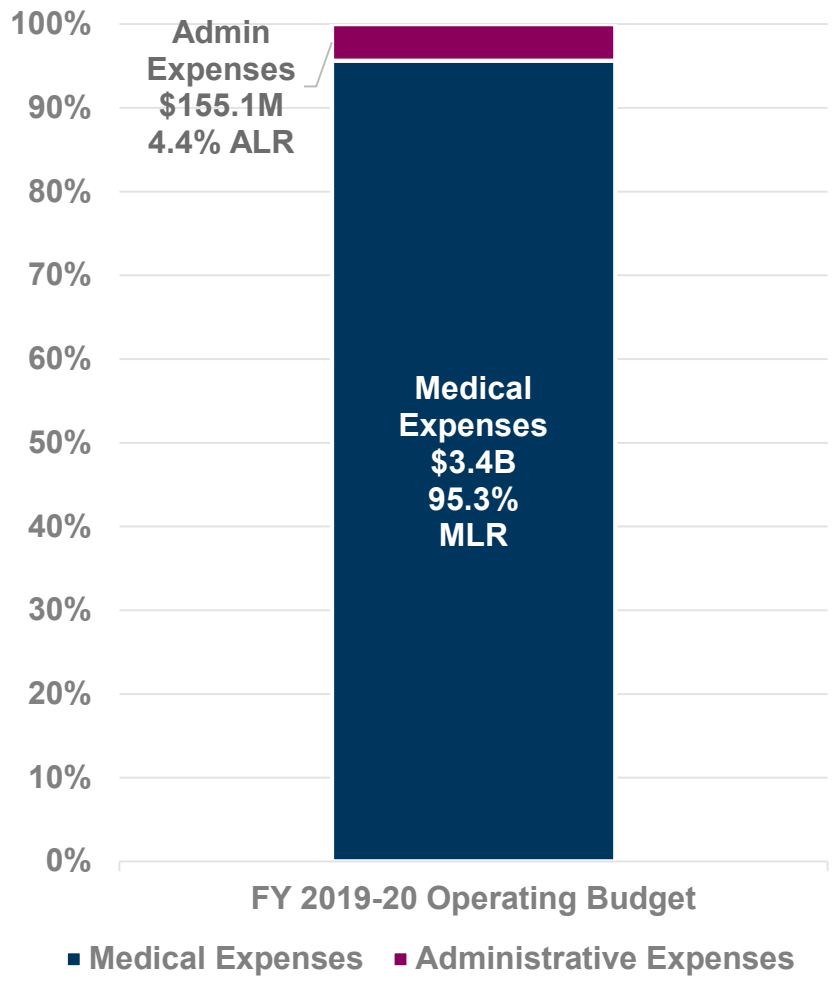
- Capitation
  - Provider paid a per member per month payment for each enrolled member
  - Receives payment regardless of whether or not a member seeks care
  - At-risk arrangement
- Fee-for-Service
  - Provider paid a fee for each particular service rendered
  - Receives payment for each visit
  - No risk arrangement
- Shared Risk
  - Capitation and Fee-for Service arrangement
  - Risk pool shared between CalOptima and health network

Provider Risk Arrangements (cont.)

Model	Professional	Hospital	Pharmacy	Other Medical	Membership Distribution*
Kaiser	Capitation	Capitation	Capitation	Capitation	6%
HMO	Capitation	Capitation	Fee-For-Service	Fee-For-Service	16%
PHC	Capitation	Capitation	Fee-For-Service	Fee-For-Service	29%
SRG	Capitation	Fee-For-Service	Fee-For-Service	Fee-For-Service	24%
CCN/COD	Fee-For-Service	Fee-For-Service	Fee-For-Service	Fee-For-Service	25%

* Membership Distribution based on March 2020 Medi-Cal actual enrollment
CCN/COD Member Distribution includes dual eligible and COD-Admin enrollment

Operating Budget



Source: FY 2019-20 Operating Budget (6/6/19 COBAR)

- Medical Expenses
  - Provider capitation payments
  - Claims payments to hospitals & providers
  - Prescription drugs
  - Care management & care coordination activities
- Administrative Expenses
  - Salaries & benefits
  - Professional fees
  - Purchased services
  - Printing & postage
  - Other Operating expenses

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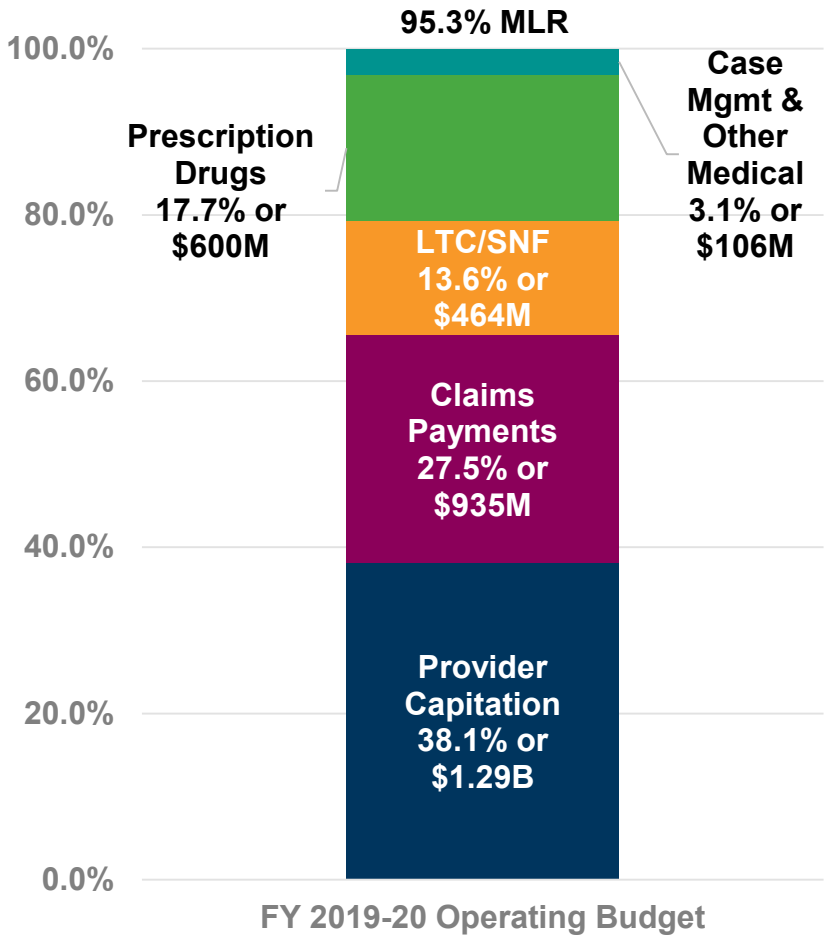
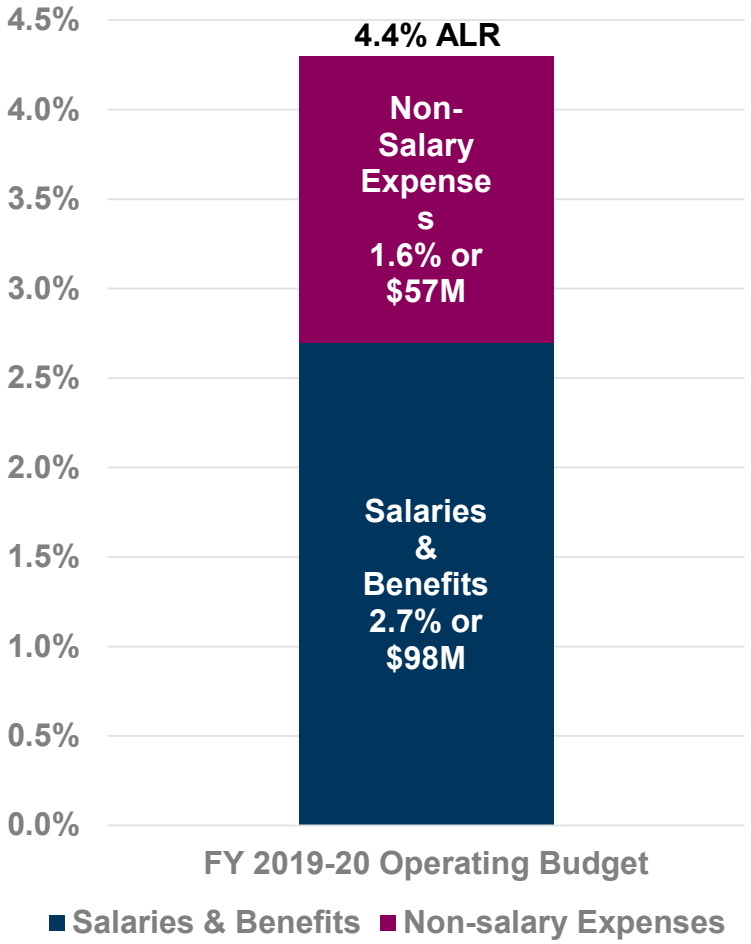
Operating Budget: Medical Expenses

- Driven primarily by program, utilization, unit cost, and service mix
- Provider payments are continually evaluated for reasonability and sufficiency
- Goal is to maximize quality and access to care for members



Operating Budget: Administrative Expenses

- Includes salary and non-salary expenses
  - Personnel levels dependent on membership, utilization level and regulatory requirements
- Process
  - Budget prepares forecast based on 12-month historical run-rate
  - Purchasing Department reviews all contract obligations
  - Departments identify resource requirements
  - Sr. Management reviews and approves their departments' budgets



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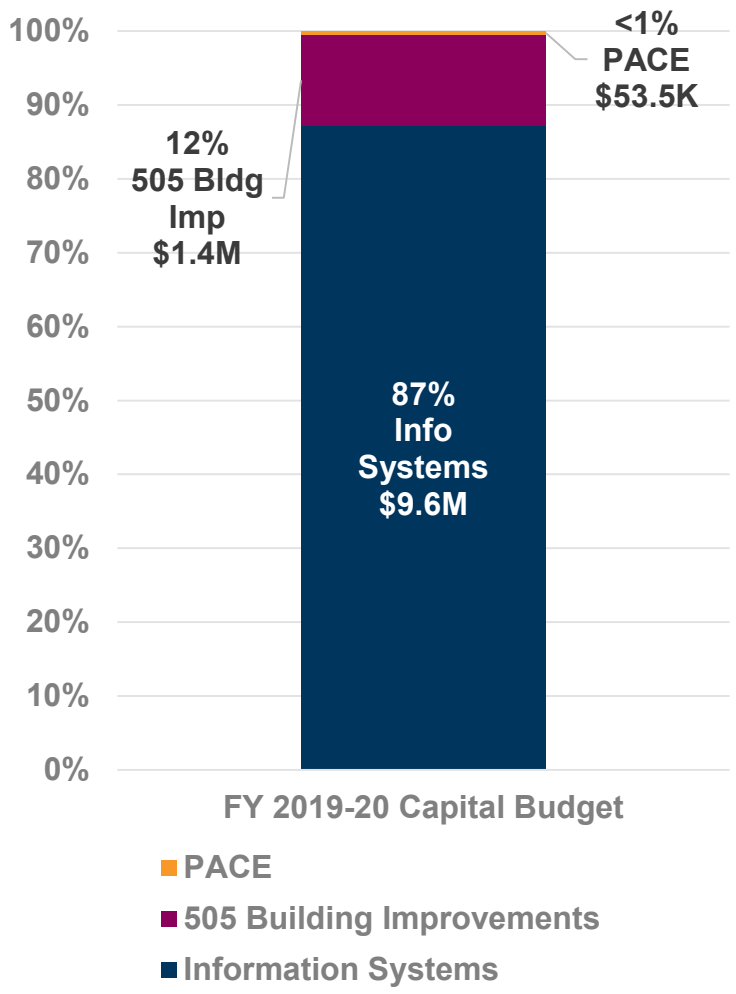
Capital Budget



- 3 Categories
  - Information Systems: Information technology infrastructure needs
  - 505 Building Improvements
  - PACE center
- Process
  - Departments submit requests for capital projects based on strategic and operational needs
  - Information Services Department reviews technology requests

Enrollment Projection: Summary

TOTAL MEMBER MONTHS

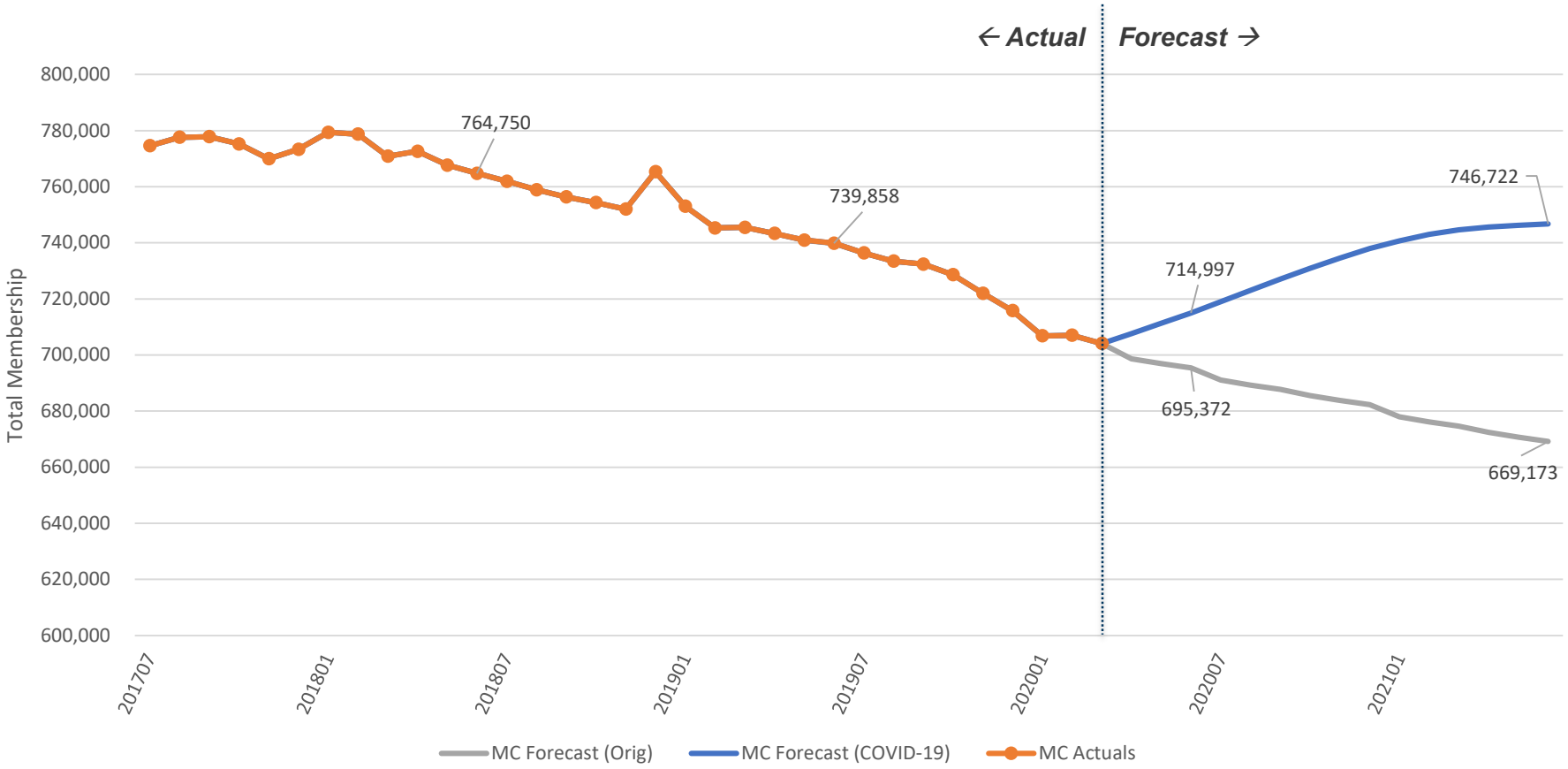
LOB	FY 2018	FY 2019	FY 2020	FY 2021	'19/'18 Δ (#)	'19/'18 Δ (%)	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/20 Δ (#)	'21/20 Δ (%)
MC	9,282,721	9,016,940	8,620,589	8,839,582	(265,781)	-2.86%	(396,351)	-4.40%	218,993	2.54%
OCC	181,399	174,094	170,462	167,856	(7,305)	-4.03%	(3,632)	-2.09%	(2,606)	-1.53%
OC	16,418	17,344	17,474	16,536	926	5.64%	130	0.75%	(938)	-5.37%
PACE	2,878	3,657	4,586	5,211	779	27.07%	929	25.40%	625	13.63%
TOTAL	**9,483,416**	**9,212,035**	**8,813,111**	**9,029,185**	**(271,381)**	**-2.86%**	**(398,924)**	**-4.33%**	**216,074**	**2.45%**

MEMBERSHIP (JUNE OF EACH FISCAL YEAR)

LOB	FY 2018	FY 2019	FY 2020	FY 2021	'19/'18 Δ (#)	'19/'18 Δ (%)	'20/'19 Δ (#)	'20/'19 Δ (%)	'21/20 Δ (#)	'21/20 Δ (%)
MC	764,750	739,858	714,997	746,722	(24,892)	-3.25%	(24,861)	-3.36%	31,725	4.44%
OCC	14,940	14,201	14,159	13,843	(739)	-4.95%	(42)	-0.30%	(316)	-2.23%
OC	1,416	1,535	1,378	1,378	119	8.40%	(157)	-10.23%	-	0.00%
PACE	268	327	401	472	59	22.01%	74	22.63%	71	17.71%
TOTAL	**781,374**	**755,921**	**730,935**	**762,415**	**(25,453)**	**-3.26%**	**(24,986)**	**-3.31%**	**31,480**	**4.31%**

**Based on Actuals 07/01/2017 through 02/28/2020*

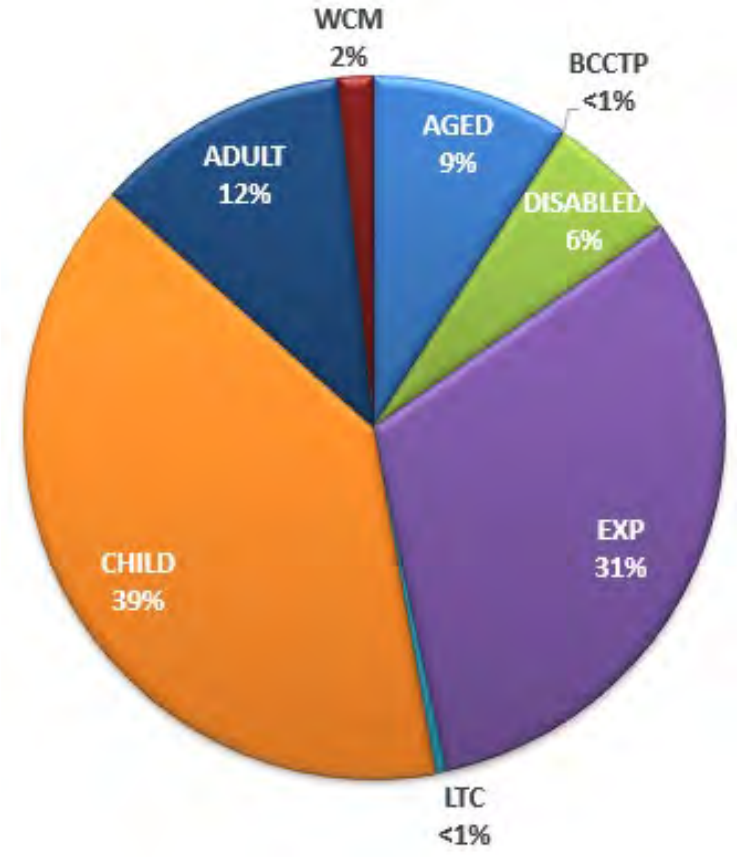
Enrollment Projection: Total Medi-Cal



Notes: Total Medi-Cal enrollment includes Medi-Cal Classic, Medi-Cal Expansion, and WCM members.
Medi-Cal Expansion enrollment is ~31% of total, WCM <2%

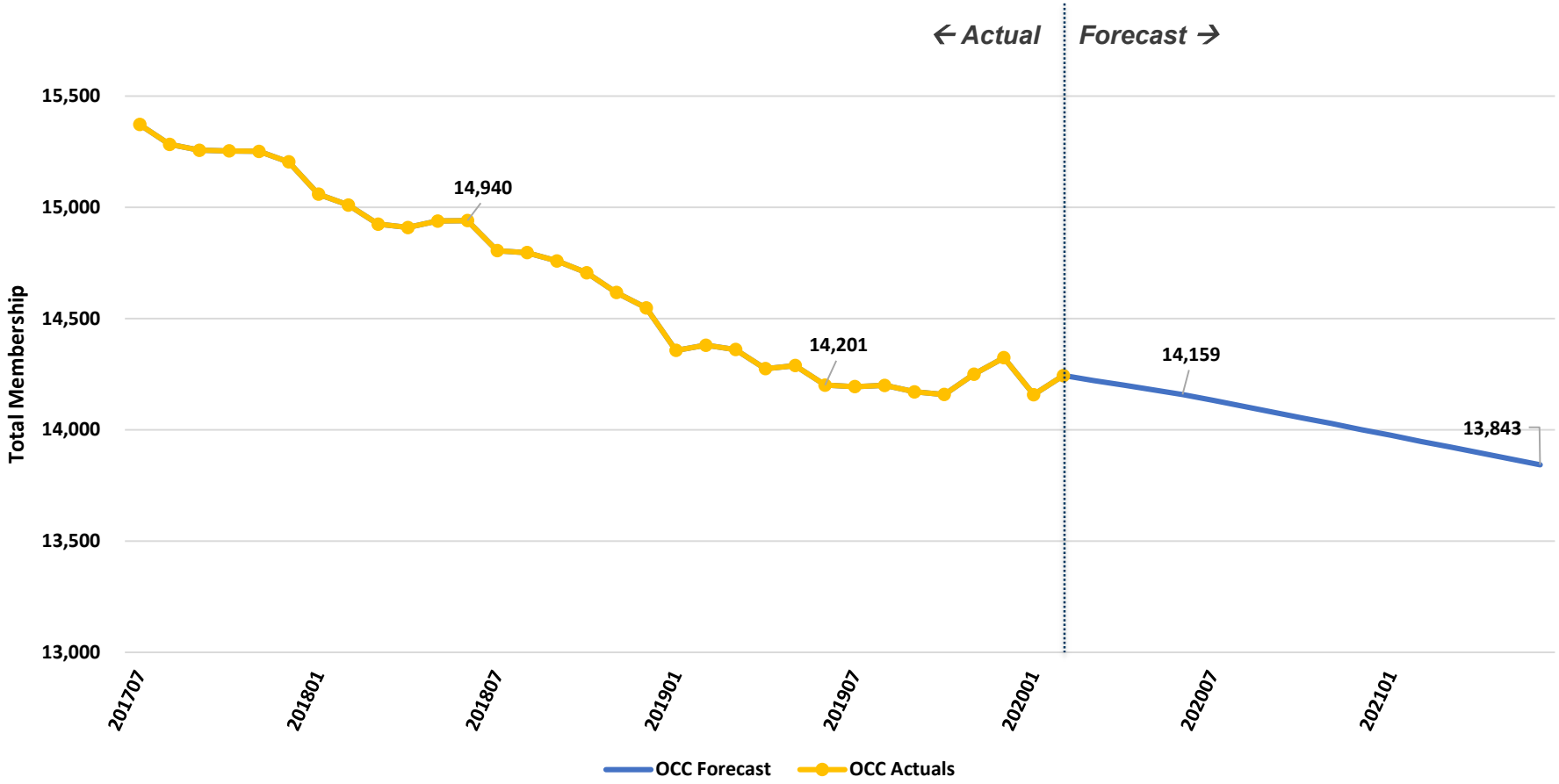
Enrollment Projection: Medi-Cal Category of Aid

- Medi-Cal enrollment defined by eligibility for aid
  - Aged
  - Breast/Cervical Cancer (BCCTP)
  - Disabled
  - Expansion
  - Long Term Care
  - Child
  - Adult
  - Whole Child Model



*** Forecasted FY 2020-21 enrollment (as of April 2020)**

Enrollment Projection: OneCare Connect



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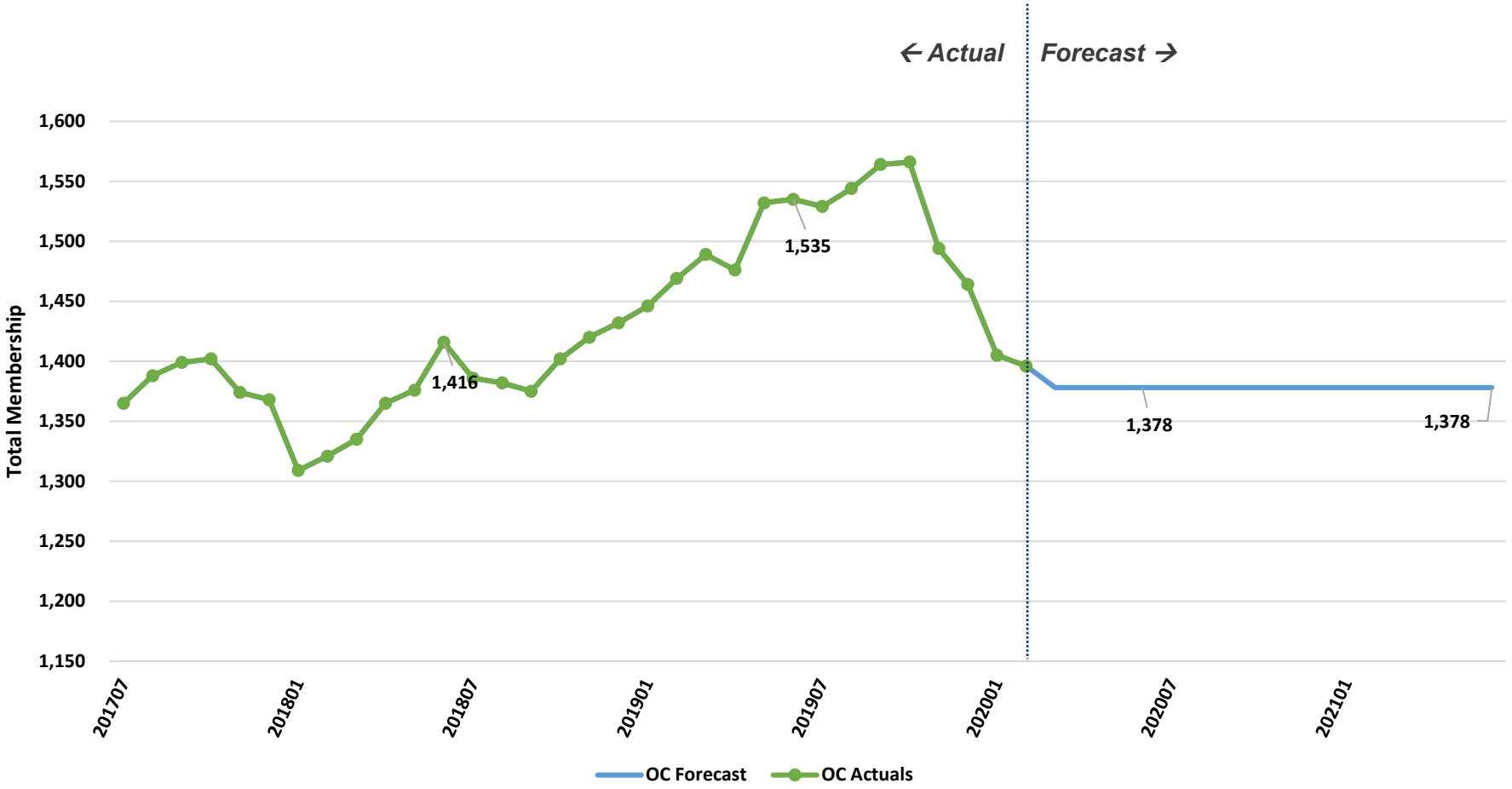
Enrollment Projection: OneCare



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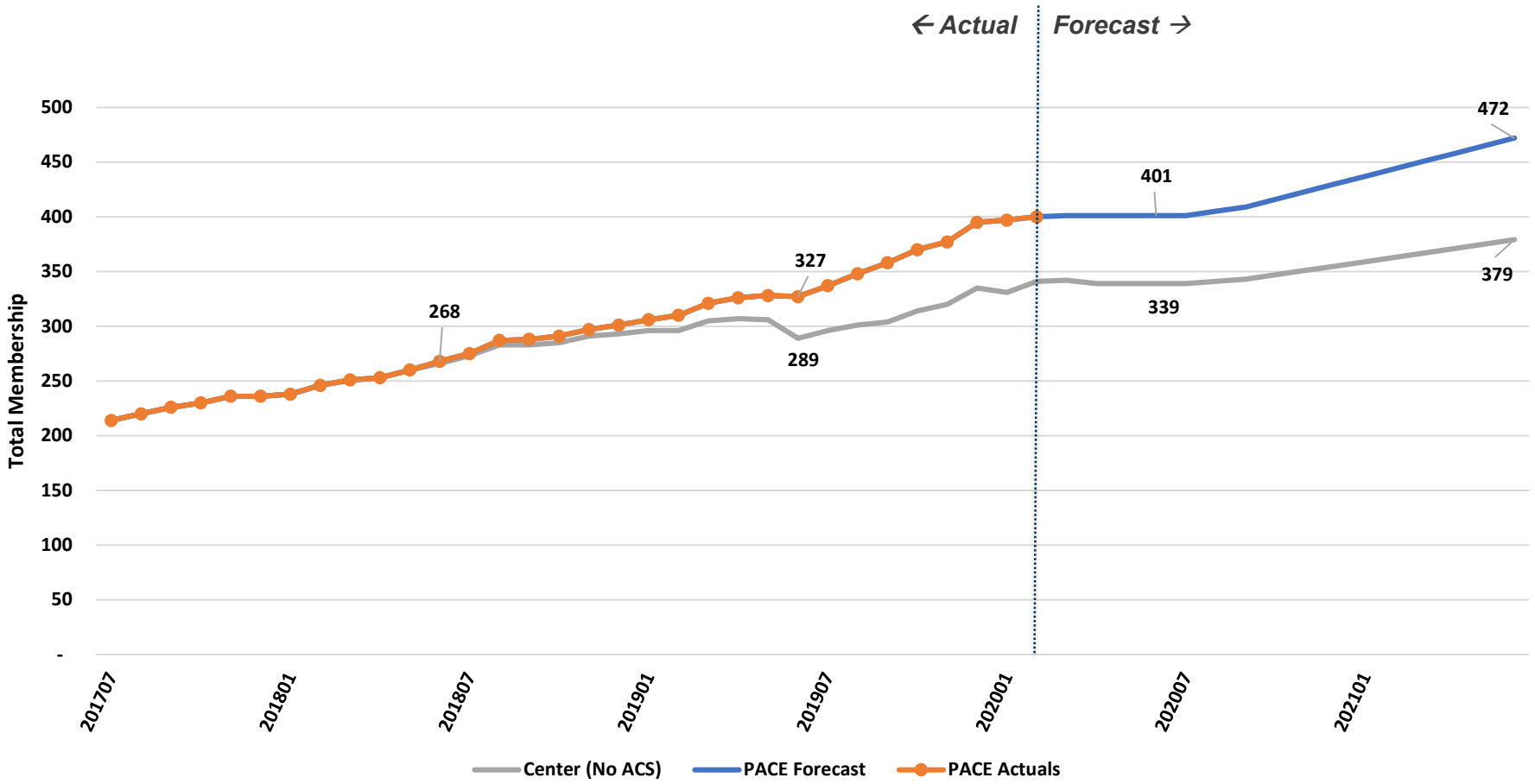
Enrollment Projection: PACE



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FY 2020-21 State Outlook

- COVID-19 Public Health Crisis
  - May Revision to the State Budget; released in mid-May
    - Update on revenues, expenditures, reserves, and enrollment estimates
  - Impact on enrollment: Initial membership projections revised
    - Counties have delayed Medi-Cal annual renewal (redetermination) processing for 90 days
    - Additional stimulus funding exempt from Medi-Cal eligibility determination
    - Largest impact expected for TANF (Adults and Children) and Medi-Cal Expansion categories of aid
    - Changes in enrollment will have a direct impact on both revenues and expenses
  - Impact on medical expenses: Projected medical expense trends revised to account for a slightly lower average acuity with the newly added population

Budget Considerations: Medi-Cal Revenue

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

- DHCS rate release changes
  - Transition to rate year beginning on January 1 instead of July 1

	18-Month Bridge Period	2nd Half of FY 2020-21
Dates	7/1/20 – 12/31/20	1/1/21 – 6/30/21
Budget assumption	Staff used bridge period rates for this period	• Expect Calendar Year 2021 draft rates from DHCS in October 2020 • Staff will forecast capitation rates based on available information

DHCS Rate Development Process

CalOptima submits Calendar Year 2018 data

- Reports experience to DHCS through Rate Development Template (RDT)

DHCS adjusts data to develop CY 2021 Base Data

- Makes adjustments to CalOptima's Calendar Year 2018 data to develop CY 2021 Base Data

DHCS applies CY 2021 adjustments

- Applies CY 2021 trends and program adjustments to the CY 2021 Base Data

DHCS creates CY 2021 Final Rates

- Sends rates to CalOptima in draft form; expected in October 2020
- Needs CMS approval to implement

- Expense data has 3.0 years trending
- Takes a prolonged period for DHCS to account for operational changes

Budget Considerations: Medi-Cal (cont.)

- Revenue (effective January 1, 2021)
  - Slight increase to Medi-Cal Classic revenue
  - Continue decrease to MCE revenue
  - Potential increase to WCM revenue
- Adjustments to Providers/Health Networks
  - Potential positive and negative adjustments resulting from Medi-Cal rebasing
  - CDPS risk adjustment implemented for MCE

Budget Considerations: Medi-Cal (cont.)

- Medi-Cal Managed Care Initiatives
  - CalAIM: Original start date of January 2021 has been postponed due to COVID-19
    - Budget will not include the transition of the Health Homes Program and Whole Person Care pilot to Enhanced Care Management and In Lieu of Services
  - Pharmacy benefit carve-out: Effective January 2021
    - Results in Medi-Cal revenue reduction of approximately $300 million
  - MSSP carve-out: Effective January 2021

Budget Considerations: Medicare Revenue

- 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 which is determined via bid or set to 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

Budget Considerations: OneCare Connect

- Enrollment: Slight decrease in enrollment
- Revenue
  - Slight increase to average base rate
  - Slight increase in RAF score
  - Lower Medi-Cal revenue from decrease in LTC enrollment
  - Target savings and quality withhold amounts will remain the same
  - Disenrollment rate penalties will continue to be applied
  - CARES Act of 2020 removed the 2% sequestration payment reduction from July through December 2020
  - No formal bid process
    - Part C and Part D revenue based on county FFS benchmark rates
- Impact to Providers/Health Networks
  - Percent of premium adjustments to hospital capitation effective January 2021

Budget Considerations: OneCare

- Enrollment
  - Decrease in enrollment, based on historical experience
- Revenue
  - Slight decrease in average base rate
    - Due to decrease in utilization projections used during CY 2021 bid process
  - CARES Act of 2020 removed the 2% sequestration payment reduction from July through December 2020
- Medical Expenses
  - January through June of 2021 includes supplemental benefit expenses from draft 2021 bid

Budget Considerations: PACE

- Enrollment
  - Flat enrollment due to COVID-19 through July 2020; slight increase enrollment thereafter

- Revenue
  - Medicare funding accounts for 25% of total revenue; Medi-Cal 75%
  - Increase in average Medi-Cal revenue
  - Increase in average Medicare base rate
  - Slight increase in RAF score
  - CARES Act of 2020 removed the 2% sequestration payment reduction from July through December 2020

Budget Process Timeline

Budget Preparation

- Late Feb – Early Mar: Departments prepare budgets
- Mid-Mar – End Mar: Finance meets with Departments on budget proposals
- Early Apr: CFO reviews proposed budget
- 4/2: Board Information Item on Budget: Part 1

Budget Review

- Early Apr – Mid-Apr: Executives review proposed budget; Hold additional department meetings, if needed
- Late Apr: Finalize budget and sign-off from Executives

Budget Approval

- Late Apr – Mid-May: Prepare May FAC and June BOD materials
- 5/7: Board Information Item on Budget: Part 2
- 5/21: FAC meeting
- 6/4: Board meeting

Board Approval Timeline

Date	Meeting
April 2, 2020	Part 1 of Introduction to the FY 2020-21 Budget included in Board materials • Staff directed to combine into one presentation for next meeting
May 7, 2020	Present consolidated information item to Board of Directors on Introduction to the FY 2020-21 Budget
May 21, 2020	Present FY 2020-21 budgets to Finance and Audit Committee
June 4, 2020	Present FY 2020-21 budgets to Board of Directors
July 1, 2020	Beginning of Fiscal Year 2020-21

CalOptima's Mission

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

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Financial Summary

March 2020

Board of Directors Meeting
May 7, 2020

Nancy Huang
Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

March 2020 MTD

Overall enrollment was 724,149 members

- Actual lower than budget 10,105 or 1.4%
  - Medi-Cal unfavorable to budget 10,133 or 1.4%
    - Medi-Cal Expansion (MCE) unfavorable variance of 11,162
    - Whole Child Model (WCM) unfavorable variance of 1,778
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,410
    - Temporary Assistance for Needy Families (TANF) favorable variance of 1,282
    - Long-Term Care (LTC) favorable variance of 115
  - OneCare Connect favorable to budget 180 or 1.3%
  - OneCare unfavorable to budget 149 or 9.8%
  - PACE unfavorable to budget 3 or 0.7%
- 7,921 increase or 1.1% from February
    - Medi-Cal increase of 8,029
    - OneCare Connect decrease of 94
    - OneCare decrease of 18
    - PACE increase of 4

FY 2019-20: Consolidated Enrollment (cont.)

March 2020 YTD

Overall enrollment was 6,639,471 member months

- Actual lower than budget 74,470 or 1.1%
  - Medi-Cal unfavorable to budget 75,105 or 1.1%
    - MCE unfavorable variance of 68,594
    - WCM unfavorable variance of 12,927
    - TANF unfavorable variance 4,430
    - SPD favorable variance of 10,139
    - LTC favorable variance of 706
  - OneCare Connect favorable to budget 807 or 0.6%
  - OneCare unfavorable to budget 197 or 1.5%
  - PACE favorable to budget 25 or 0.7%

FY 2019-20: Consolidated Revenues

March 2020 MTD

- Actual higher than budget $105.0 million or 35.3%
  - ➢ Medi-Cal favorable to budget $104.2 million or 38.8%
    - o Unfavorable volume variance of $3.8 million
    - o Favorable price variance of $108.0 million
      - $91.0 million of Directed Payment (DP) revenue
      - $14.4 million of acuity rate adjustment and updated MCE rates from the Department of Health Care Services (DHCS)
      - $1.6 million of LTC revenue from non-LTC categories of aid
      - $1.5 million of Behavioral Health Treatment (BHT) revenue
      - Offset by $3.3 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $0.5 million or 2.1%
    - o Favorable volume variance of $0.3 million
    - o Favorable price variance of $0.2 million

FY 2019-20: Consolidated Revenues (cont.)

March 2020 MTD (cont.)

- OneCare unfavorable to budget $87.6 thousand or 5.3%
  - Unfavorable volume variance of $162.8 thousand
  - Favorable price variance of $75.2 thousand
- PACE favorable to budget $402.6 thousand or 12.9%
  - Unfavorable volume variance of $23.2 thousand
  - Favorable price variance of $425.9 thousand

FY 2019-20: Consolidated Revenues (cont.)

March 2020 YTD

- Actual higher than budget $251.5 million or 9.4%
  - ➢ Medi-Cal favorable to budget $242.4 million or 10.0%
    - o Unfavorable volume variance of $27.7 million
    - o Favorable price variance of $270.1 million
      - $195.3 million of DP revenue
      - $53.0 million of CCI revenue due to updated rate and member mix
      - $37.4 million of acuity rate adjustment and updated MCE rates from DHCS
      - $12.1 million of BHT revenue
      - Offset by $25.5 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $7.1 million or 3.3%
    - o Favorable volume variance of $1.4 million
    - o Favorable price variance of $5.7 million

FY 2019-20: Consolidated Revenues (cont.)

March 2020 YTD (cont.)

- OneCare favorable to budget $625.6 thousand or 4.2%
  - Unfavorable volume variance of $214.7 thousand
  - Favorable price variance of $840.4 thousand
- PACE favorable to budget $1.3 million or 5.0%
  - Favorable volume variance of $0.2 million
  - Favorable price variance of $1.1 million

FY 2019-20: Consolidated Medical Expenses

March 2020 MTD

- Actual higher than budget $97.1 million or 33.9%
  - ➢ Medi-Cal unfavorable variance of $96.2 million or 37.2%
    - o Favorable volume variance of $3.6 million
    - o Unfavorable price variance of $99.8 million
      - Reinsurance & Other expenses unfavorable variance of $89.8 million due to DP
      - Professional Claims unfavorable variance of $6.5 million due to crossover claims
      - Prescription Drug claims unfavorable variance of $6.4 million due to increased utilization
      - Provider Capitation favorable variance of $2.6 million
  - ➢ OneCare Connect unfavorable variance of $0.7 million or 3.0%
    - o Unfavorable volume variance of $0.3 million
    - o Unfavorable price variance of $0.4 million

FY 2019-20: Consolidated Medical Expenses (cont.)

March 2020 YTD

- Actual higher than budget $258.0 million or 10.1%
  - ➢ Medi-Cal unfavorable variance of $254.8 million or 11.1%
    - o Favorable volume variance of $26.3 million
    - o Unfavorable price variance of $281.0 million
      - Reinsurance and Other Expense category unfavorable variance of $182.9 million due to $195.5 million of DP, offset by favorable variance in Homeless Health Initiative
      - Facilities Claims unfavorable variance of $41.4 million
      - Professional Claims unfavorable variance of $33.2 million
      - MLTSS unfavorable variance of $16.7 million
  - ➢ OneCare Connect unfavorable variance of $4.5 million or 2.2%
    - o Unfavorable volume variance of $1.3 million
    - o Unfavorable price variance of $3.2 million

Medical Loss Ratio (MLR)

- March 2020 MTD: Actual: 95.4% Budget: 96.5%
- March 2020 YTD: Actual: 95.8% Budget: 95.2%

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FY 2019-20: Consolidated Administrative Expenses

March 2020 MTD

- Actual lower than budget $2.1 million or 15.4%
  - Salaries, wages and benefits: favorable variance of $0.8 million
  - Other categories: favorable variance of $1.3 million

March 2020 YTD

- Actual lower than budget $16.1 million or 13.7%
  - Salaries, wages and benefits: favorable variance of $6.9 million
  - Other categories: favorable variance of $9.2 million

Administrative Loss Ratio (ALR)

- March 2020 MTD: Actual: 2.9% Budget: 4.6%
- March 2020 YTD: Actual: 3.4% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% MTD and 3.7% YTD

FY 2019-20: Change in Net Assets

March 2020 MTD

- $7.5 million change in net assets
- $9.4 million favorable to budget
  - Higher than budgeted revenue of $105.0 million
  - Higher than budgeted medical expenses of $97.1 million
  - Lower than budgeted administrative expenses of $2.1 million
  - Lower than budgeted investment and other income of $0.6 million

March 2020 YTD

- $48.4 million change in net assets
- $25.6 million favorable to budget
  - Higher than budgeted revenue of $251.5 million
  - Higher than budgeted medical expenses of $258.0 million
  - Lower than budgeted administrative expenses of $16.1 million
  - Higher than budgeted investment and other income of $16.1 million

Enrollment Summary: March 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,242	66,241	1	0.0%	Aged	592,981	591,430	1,551	0.3%
502	615	(113)	(18.4%)	BCCTP	4,773	5,535	(762)	(13.8%)
45,109	43,587	1,522	3.5%	Disabled	402,888	393,538	9,350	2.4%
278,561	276,635	1,926	0.7%	TANF Child	2,536,630	2,538,817	(2,187)	(0.1%)
83,631	84,275	(644)	(0.8%)	TANF Adult	773,375	775,618	(2,243)	(0.3%)
3,519	3,404	115	3.4%	LTC	31,342	30,636	706	2.3%
224,582	235,744	(11,162)	(4.7%)	MCE	2,049,947	2,118,541	(68,594)	(3.2%)
11,162	12,940	(1,778)	(13.7%)	WCM	103,533	116,460	(12,927)	(11.1%)
713,308	**723,441**	**(10,133)**	**(1.4%)**	**Medi-Cal Total**	**6,495,470**	**6,570,575**	**(75,105)**	**(1.1%)**
14,077	**13,897**	**180**	**1.3%**	**OneCare Connect**	**127,307**	**126,500**	**807**	**0.6%**
1,364	**1,513**	**(149)**	**(9.8%)**	**OneCare**	**13,332**	**13,529**	**(197)**	**(1.5%)**
400	**403**	**(3)**	**(0.7%)**	**PACE**	**3,362**	**3,337**	**25**	**0.7%**
729,149	**739,254**	**(10,105)**	**(1.4%)**	**CalOptima Total**	**6,639,471**	**6,713,941**	**(74,470)**	**(1.1%)**

Financial Highlights: March 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
729,149	739,254	(10,105)	(1.4%)	Member Months	6,639,471	6,713,941	(74,470)	(1.1%)
402,216,513	297,201,816	105,014,697	35.3%	Revenues	2,926,735,188	2,675,282,490	251,452,698	9.4%
383,903,326	286,815,601	(97,087,725)	(33.9%)	Medical Expenses	2,804,915,275	2,546,891,566	(258,023,710)	(10.1%)
11,505,316	13,604,361	2,099,045	15.4%	Administrative Expenses	100,794,302	116,852,902	16,058,600	13.7%
6,807,871	**(3,218,146)**	**10,026,017**	**311.5%**	**Operating Margin**	**21,025,611**	**11,538,022**	**9,487,588**	**82.2%**
646,007	1,250,000	(603,993)	(48.3%)	Non Operating Income (Loss)	27,334,791	11,250,000	16,084,791	143.0%
7,453,878	**(1,968,146)**	**9,422,024**	**478.7%**	**Change in Net Assets**	**48,360,402**	**22,788,022**	**25,572,380**	**112.2%**
95.4%	96.5%	1.1%		Medical Loss Ratio	95.8%	95.2%	(0.6%)	
2.9%	4.6%	1.7%		Administrative Loss Ratio	3.4%	4.4%	0.9%	
1.7%	(1.1%)	2.8%		Operating Margin Ratio	0.7%	0.4%	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%				*Administrative Loss Ratio (excluding Directed Payments)	3.7%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Consolidated Performance Actual vs. Budget: March 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
7.9	(2.0)	9.8	Medi-Cal	23.8	22.4	1.4
(1.3)	(1.3)	0.0	OCC	(6.8)	(11.5)	4.7
(0.4)	(0.1)	(0.3)	OneCare	0.4	(1.0)	1.4
0.6	0.2	0.4	PACE	3.6	1.7	2.0
6.8	**(3.2)**	**10.0**	**Operating**	**21.0**	**11.5**	**9.5**
0.6	1.3	(0.6)	Inv./Rental Inc, MCO tax	27.3	11.3	16.1
0.6	**1.3**	**(0.6)**	**Non-Operating**	**27.3**	**11.3**	**16.1**
7.5	**(2.0)**	**9.4**	**TOTAL**	**48.4**	**22.8**	**25.6**

Consolidated Revenue & Expense: March 2020 MTD

	Medi-Cal Classic*	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	477,564	224,582	11,162	713,308	14,077	1,364	400	729,149
REVENUES								
Capitation Revenue	197,437,143	$ 152,881,027	$ 22,234,632	$ 372,552,802	$ 24,573,194	$ 1,565,618	$ 3,524,900	$ 402,216,513
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	197,437,143	152,881,027	22,234,632	372,552,802	24,573,194	1,565,618	3,524,900	402,216,513
MEDICAL EXPENSES								
Provider Capitation	37,925,700	41,962,965	9,736,868	89,625,534	10,958,029	466,521		101,050,083
Facilities	24,418,061	22,825,667	3,348,855	50,592,583	3,918,192	688,741	672,112	55,871,627
Professional Claims	19,834,363	7,997,069	1,996,294	29,827,726	752,954	76,380	766,374	31,423,433
Prescription Drugs	40,899,555	3,283,969	6,162,373	50,345,897	5,963,644	495,903	250,533	57,055,978
MLTSS	33,096,069	2,642,467	363,816	36,102,353	1,254,384	59,105	34,850	37,450,691
Medical Management	2,232,979	1,511,832	295,793	4,040,604	1,103,023	29,526	836,903	6,010,056
Quality Incentives	894,005	449,017	140,263	1,483,285	195,410		5,000	1,683,695
Reinsurance & Other	54,251,414	38,683,119	31,206	92,965,739	195,623		196,399	93,357,761
Total Medical Expenses	213,552,147	119,356,106	22,075,468	354,983,721	24,341,258	1,816,176	2,762,170	383,903,326
Medical Loss Ratio	108.2%	78.1%	99.3%	95.3%	99.1%	116.0%	78.4%	95.4%
GROSS MARGIN	**(16,115,004)**	**33,524,921**	**159,164**	**17,569,081**	**231,936**	**(250,558)**	**762,730**	**18,313,188**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,720,461	753,261	75,825	142,914	7,692,461
Professional fees				200,988	4,000	15,000	123	220,112
Purchased services				931,229	81,189	8,823	4,820	1,026,061
Printing & Postage				278,531	70,817	5,200	23,156	377,704
Depreciation & Amortization				273,042			2,057	275,099
Other expenses				1,649,178	60,497	-	2,614	1,712,290
Indirect cost allocation & Occupancy				(353,405)	579,990	28,340	(53,336)	201,589
Total Administrative Expenses				9,700,025	1,549,755	133,188	122,348	11,505,316
Admin Loss Ratio				2.6%	6.3%	8.5%	3.5%	2.9%
INCOME (LOSS) FROM OPERATIONS				7,869,056	(1,317,820)	(383,747)	640,382	6,807,871
INVESTMENT INCOME								(476,268)
TOTAL MCO TAX				1,169,888				1,169,888
TOTAL GRANT INCOME				(47,663)				(47,663)
OTHER INCOME				50				50
CHANGE IN NET ASSETS				**$ 8,991,331**	**$ (1,317,820)**	**$ (383,747)**	**$ 640,382**	**$ 7,453,878**
BUDGETED CHANGE IN NET ASSETS				(1,967,723)	(1,327,322)	(117,763)	194,662	(1,968,146)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 10,959,053	$ 9,502	$ (265,984)	$ 445,720	$ 9,422,024

* Year-to-Date reclassification of prescription drug expense from Medi-Cal Expansion to Medi-Cal Classic

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Consolidated Revenue & Expense: March 2020 YTD

	Medi-Cal Classic*	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,341,989	2,049,947	103,533	6,495,469	127,307	13,332	3,362	6,639,470
REVENUES								
Capitation Revenue	1,428,990,429	$ 1,026,843,471	$ 206,060,661	$ 2,661,894,561	$ 222,256,554	$ 15,372,629	$ 27,211,444	$ 2,926,735,188
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,428,990,429	1,026,843,471	206,060,661	2,661,894,561	222,256,554	15,372,629	27,211,444	2,926,735,188
MEDICAL EXPENSES								
Provider Capitation	349,160,189	393,943,944	90,242,437	833,346,571	98,879,547	4,309,216		936,535,334
Facilities	226,693,188	195,509,811	48,948,529	471,151,528	33,541,218	3,820,989	5,918,180	514,431,915
Professional Claims	161,739,331	63,915,929	13,278,163	238,933,422	6,804,523	466,410	5,064,571	251,268,926
Prescription Drugs	175,335,045	180,387,821	50,624,188	406,347,054	50,935,839	4,629,207	2,123,105	464,035,204
MLTSS	307,804,027	23,621,827	15,094,415	346,520,269	12,080,517	160,380	331,476	359,092,642
Medical Management	19,042,195	11,346,563	2,396,273	32,785,031	9,271,719	335,186	6,551,564	48,943,499
Quality Incentives	8,212,412	4,148,732	1,270,011	13,631,155	1,814,500		196,235	15,641,890
Reinsurance & Other	122,079,863	89,045,619	307,561	211,433,043	1,659,972		1,872,850	214,965,864
Total Medical Expenses	1,370,066,249	961,920,244	222,161,578	2,554,148,072	214,987,835	13,721,389	22,057,980	2,804,915,275
Medical Loss Ratio	95.9%	93.7%	107.8%	96.0%	96.7%	89.3%	81.1%	95.8%
GROSS MARGIN	**58,924,180**	**64,923,227**	**(16,100,917)**	**107,746,490**	**7,268,719**	**1,651,240**	**5,153,464**	**121,819,913**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				57,996,091	6,449,989	595,610	1,262,266	66,303,956
Professional fees				1,773,329	460,486	174,371	1,506	2,409,692
Purchased services				7,314,886	1,264,438	119,728	71,527	8,770,578
Printing & Postage				3,030,687	544,491	42,746	105,646	3,723,571
Depreciation & Amortization				3,006,362			18,714	3,025,075
Other expenses				13,187,130	281,948	2,237	35,160	13,506,475
Indirect cost allocation & Occupancy				(2,360,150)	5,028,550	347,805	38,749	3,054,954
Total Administrative Expenses				83,948,334	14,029,902	1,282,498	1,533,568	100,794,302
Admin Loss Ratio				3.2%	6.3%	8.3%	5.6%	3.4%
INCOME (LOSS) FROM OPERATIONS				23,798,156	(6,761,183)	368,742	3,619,896	21,025,611
INVESTMENT INCOME								29,194,355
TOTAL MCO TAX				(1,812,360)				(1,812,360)
TOTAL GRANT INCOME				(47,748)				(47,748)
OTHER INCOME				544				544
CHANGE IN NET ASSETS				**$ 21,938,591**	**$ (6,761,183)**	**$ 368,742**	**$ 3,619,896**	**$ 48,360,402**
BUDGETED CHANGE IN NET ASSETS				22,396,122	(11,510,726)	(998,822)	1,651,448	22,788,022
VARIANCE TO BUDGET - FAV (UNFAV)				$ (457,531)	$ 4,749,543	$ 1,367,564	$ 1,968,448	$ 25,572,380

* Year-to-Date reclassification of prescription drug expense from Medi-Cal Expansion to Medi-Cal Classic

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Balance Sheet:
As of March 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$382,898,813	Accounts Payable	$41,752,651
Investments	518,455,688	Medical Claims liability	781,885,602
Capitation receivable	387,689,990	Accrued Payroll Liabilities	13,997,455
Receivables - Other	51,102,708	Deferred Revenue	30,787,390
Prepaid expenses	6,893,911	Deferred Lease Obligations	170,710
		Capitation and Withholds	132,250,984
Total Current Assets	**1,347,041,111**	**Total Current Liabilities**	**1,000,844,794**
Capital Assets			
Furniture & Equipment	37,266,060		
Building/Leasehold Improvements	11,736,817		
505 City Parkway West	50,489,717		
	99,492,593		
Less: accumulated depreciation	(51,440,146)		
Capital assets, net	48,052,447		
		Other (than pensions) post employment benefits liability	25,821,090
Other Assets		Net Pension Liabilities	23,529,538
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,050,195,422**
Cash and Cash Equivalents	7,610,600		
Long-term Investments	569,212,008	**Deferred Inflows**	
Total Board-designated Assets	576,822,608	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	635,321,521	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,030,415,079**	TNE	100,958,386
		Funds in Excess of TNE	882,944,885
Deferred Outflows		**TOTAL NET POSITION**	983,903,272
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,041,505,528**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,041,505,528**

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Board Designated Reserve and TNE Analysis
As of March 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	157,864,886				
	Tier 1 - Logan Circle	156,881,532				
	Tier 1 - Wells Capital	157,161,784				
Board-designated Reserve		471,908,201	320,551,041	501,197,938	151,357,160	(29,289,737)
TNE Requirement	Tier 2 - Logan Circle	104,914,407	100,958,386	100,958,386	3,956,021	3,956,021
	Consolidated:	**576,822,608**	**421,509,427**	**602,156,324**	**155,313,181**	**(25,333,716)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

March 2020

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CalOptima - Consolidated
Financial Highlights
For the Nine Months Ended March 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
729,149	739,254	(10,105)	(1.4%)	Member Months	6,639,471	6,713,941	(74,470)	(1.1%)
402,216,513	297,201,816	105,014,697	35.3%	Revenues	2,926,735,188	2,675,282,490	251,452,698	9.4%
383,903,326	286,815,601	(97,087,725)	(33.9%)	Medical Expenses	2,804,915,275	2,546,891,566	(258,023,710)	(10.1%)
11,505,316	13,604,361	2,099,045	15.4%	Administrative Expenses	100,794,302	116,852,902	16,058,600	13.7%
6,807,871	**(3,218,146)**	**10,026,017**	**311.5%**	**Operating Margin**	**21,025,611**	**11,538,022**	**9,487,588**	**82.2%**
646,007	1,250,000	(603,993)	(48.3%)	Non Operating Income (Loss)	27,334,791	11,250,000	16,084,791	143.0%
7,453,878	**(1,968,146)**	**9,422,024**	**478.7%**	**Change in Net Assets**	**48,360,402**	**22,788,022**	**25,572,380**	**112.2%**
95.4%	96.5%	1.1%		Medical Loss Ratio	95.8%	95.2%	(0.6%)	
2.9%	4.6%	1.7%		Administrative Loss Ratio	3.4%	4.4%	0.9%	
1.7%	(1.1%)	2.8%		Operating Margin Ratio	0.7%	0.4%	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.7%				*Administrative Loss Ratio (excluding Directed Payments)	3.7%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Nine Months Ended March 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	713,308	723,441	(10,133)	(1.4%)
OneCare Connect	14,077	13,897	180	1.3%
OneCare	1,364	1,513	(149)	(9.8%)
PACE	400	403	(3)	(0.7%)
Total	729,149	739,254	(10,105)	(1.4%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,991	$ (1,968)	$ 10,959	556.9%
OneCare Connect	(1,318)	(1,327)	9	0.7%
OneCare	(384)	(118)	(266)	(225.4%)
PACE	640	195	446	228.2%
505 Bldg.	-	-	-	0.0%
Investment Income	(476)	1,250	(1,726)	(138.1%)
Total	$ 7,454	$ (1,968)	$ 9,422	478.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	95.3%	96.5%	1.2
OneCare Connect	99.1%	98.1%	(0.9)
OneCare	116.0%	98.1%	(17.9)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,700	$ 11,490	$ 1,790	15.6%
OneCare Connect	1,550	1,777	227	12.8%
OneCare	133	149	16	10.6%
PACE	122	188	66	35.1%
Total	$ 11,505	$ 13,604	$ 2,099	15.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,062	1,183	121
OneCare Connect	200	211	11
OneCare	10	9	(1)
PACE	78	93	14
Total	1,351	1,496	145

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	672	612	60
OneCare Connect	70	66	5
OneCare	130	163	(33)
PACE	5	4	1
Total	877	845	33

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,495,470	6,570,575	(75,105)	(1.1%)
OneCare Connect	127,307	126,500	807	0.6%
OneCare	13,332	13,529	(197)	(1.5%)
PACE	3,362	3,337	25	0.7%
Total	6,639,471	6,713,941	(74,470)	(1.1%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 21,939	$ 22,396	$ (458)	(2.0%)
OneCare Connect	(6,761)	(11,511)	4,750	41.3%
OneCare	369	(999)	1,368	136.9%
PACE	3,620	1,651	1,968	119.3%
505 Bldg.	-	-	-	0.0%
Investment Income	29,194	11,250	17,944	159.5%
Total	$ 48,360	$ 22,788	$ 25,572	112.2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.0%	95.0%	(0.9)
OneCare Connect	96.7%	97.8%	1.1
OneCare	89.3%	97.8%	8.5

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 83,948	$ 97,689	$ 13,741	14.1%
OneCare Connect	14,030	16,197	2,167	13.4%
OneCare	1,282	1,324	41	3.1%
PACE	1,534	1,643	109	6.7%
Total	$ 100,794	$ 116,853	$ 16,059	13.7%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	9,339	10,497	1,158
OneCare Connect	1,733	1,851	117
OneCare	85	84	(2)
PACE	653	829	176
Total	11,810	13,260	1,449

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	696	626	70
OneCare Connect	73	68	5
OneCare	156	162	(6)
PACE	5	4	1
Total	930	860	70

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended March 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	729,149		739,254		(10,105)	
REVENUE						
Medi-Cal	$ 372,552,802	$ 522.29	$ 268,347,082	$ 370.93	$ 104,205,719	$ 151.36
OneCare Connect	24,573,194	1,745.63	24,079,201	1,732.82	493,993	12.81
OneCare	1,565,618	1,147.81	1,653,248	1,092.70	(87,630)	55.11
PACE	3,524,900	8,812.25	3,122,285	7,747.61	402,615	1,064.64
Total Operating Revenue	402,216,513	551.62	297,201,816	402.03	105,014,697	149.59
MEDICAL EXPENSES						
Medi-Cal	354,983,721	497.66	258,824,402	357.77	(96,159,319)	(139.89)
OneCare Connect	24,341,258	1,729.15	23,629,977	1,700.49	(711,281)	(28.66)
OneCare	1,816,176	1,331.51	1,622,056	1,072.08	(194,120)	(259.43)
PACE	2,762,170	6,905.43	2,739,166	6,796.94	(23,004)	(108.49)
Total Medical Expenses	383,903,326	526.51	286,815,601	387.98	(97,087,725)	(138.53)
GROSS MARGIN	18,313,188	25.11	10,386,215	14.05	7,926,972	11.06
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,692,461	10.55	8,494,192	11.49	801,731	0.94
Professional fees	220,112	0.30	499,003	0.68	278,891	0.38
Purchased services	1,026,061	1.41	1,532,026	2.07	505,965	0.66
Printing & Postage	377,704	0.52	515,972	0.70	138,268	0.18
Depreciation & Amortization	275,099	0.38	457,866	0.62	182,767	0.24
Other expenses	1,712,290	2.35	1,727,417	2.34	15,127	(0.01)
Indirect cost allocation & Occupancy expense	201,589	0.28	377,885	0.51	176,296	0.23
Total Administrative Expenses	11,505,316	15.78	13,604,361	18.40	2,099,045	2.62
INCOME (LOSS) FROM OPERATIONS	6,807,871	9.34	(3,218,146)	(4.35)	10,026,017	13.69
INVESTMENT INCOME						
Interest income	2,603,058	3.57	1,250,000	1.69	1,353,058	1.88
Realized gain/(loss) on investments	630,581	0.86	-	-	630,581	0.86
Unrealized gain/(loss) on investments	(3,709,907)	(5.09)	-	-	(3,709,907)	(5.09)
Total Investment Income	(476,268)	(0.65)	1,250,000	1.69	(1,726,268)	(2.34)
TOTAL MCO TAX	1,169,888	1.60	-	-	1,169,888	1.60
TOTAL GRANT INCOME	(47,663)	(0.07)	-	-	(47,663)	(0.07)
OTHER INCOME	50	-	-	-	50	-
CHANGE IN NET ASSETS	**7,453,878**	**10.22**	**(1,968,146)**	**(2.66)**	**9,422,024**	**12.88**
MEDICAL LOSS RATIO	**95.4%**		**96.5%**		**1.1%**	
ADMINISTRATIVE LOSS RATIO	**2.9%**		**4.6%**		**1.7%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Nine Months Ended March 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,639,471		6,713,941		(74,470)	
REVENUE						
Medi-Cal	$ 2,661,894,561	$ 409.81	$ 2,419,477,695	$ 368.23	$ 242,416,866	$ 41.58
OneCare Connect	222,256,554	1,745.83	215,142,423	1,700.73	7,114,131	45.10
OneCare	15,372,629	1,153.06	14,746,980	1,090.03	625,649	63.03
PACE	27,211,444	8,093.83	25,915,392	7,766.07	1,296,052	327.76
Total Operating Revenue	2,926,735,188	440.81	2,675,282,490	398.47	251,452,698	42.34
MEDICAL EXPENSES						
Medi-Cal	2,554,148,072	393.22	2,299,392,424	349.95	(254,755,648)	(43.27)
OneCare Connect	214,987,835	1,688.74	210,456,183	1,663.69	(4,531,652)	(25.05)
OneCare	13,721,389	1,029.21	14,422,057	1,066.01	700,668	36.80
PACE	22,057,980	6,560.97	22,620,902	6,778.81	562,922	217.84
Total Medical Expenses	2,804,915,275	422.46	2,546,891,566	379.34	(258,023,710)	(43.12)
GROSS MARGIN	121,819,913	18.35	128,390,924	19.13	(6,571,011)	(0.78)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	66,303,956	9.99	73,179,617	10.90	6,875,661	0.91
Professional fees	2,409,692	0.36	4,299,980	0.64	1,890,288	0.28
Purchased services	8,770,578	1.32	11,201,234	1.67	2,430,656	0.35
Printing & Postage	3,723,571	0.56	5,049,698	0.75	1,326,127	0.19
Depreciation & Amortization	3,025,075	0.46	4,120,794	0.61	1,095,719	0.15
Other expenses	13,506,475	2.03	15,558,303	2.32	2,051,828	0.29
Indirect cost allocation & Occupancy expense	3,054,954	0.46	3,443,276	0.51	388,322	0.05
Total Administrative Expenses	100,794,302	15.18	116,852,902	17.40	16,058,600	2.22
INCOME (LOSS) FROM OPERATIONS	21,025,611	3.17	11,538,022	1.72	9,487,588	1.45
INVESTMENT INCOME						
Interest income	24,970,208	3.76	11,250,000	1.68	13,720,208	2.08
Realized gain/(loss) on investments	2,487,799	0.37	-	-	2,487,799	0.37
Unrealized gain/(loss) on investments	1,736,348	0.26	-	-	1,736,348	0.26
Total Investment Income	29,194,355	4.40	11,250,000	1.68	17,944,355	2.72
TOTAL MCO TAX	(1,812,360)	(0.27)	-	-	(1,812,360)	(0.27)
TOTAL GRANT INCOME	(47,748)	(0.01)	-	-	(47,748)	(0.01)
OTHER INCOME	544	-	-	-	544	-
CHANGE IN NET ASSETS	**48,360,402**	**7.28**	**22,788,022**	**3.39**	**25,572,380**	**3.89**
MEDICAL LOSS RATIO	**95.8%**		**95.2%**		**-0.6%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.4%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended March 31, 2020

	Medi-Cal Classic*	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	477,564	224,582	11,162	713,308	14,077	1,364	400	729,149
REVENUES								
Capitation Revenue	197,437,143	$ 152,881,027	$ 22,234,632	$ 372,552,802	$ 24,573,194	$ 1,565,618	$ 3,524,900	$ 402,216,513
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	197,437,143	152,881,027	22,234,632	372,552,802	24,573,194	1,565,618	3,524,900	402,216,513
MEDICAL EXPENSES								
Provider Capitation	37,925,700	41,962,965	9,736,868	89,625,534	10,958,029	466,521		101,050,083
Facilities	24,418,061	22,825,667	3,348,855	50,592,583	3,918,192	688,741	672,112	55,871,627
Professional Claims	19,834,363	7,997,069	1,996,294	29,827,726	752,954	76,380	766,374	31,423,433
Prescription Drugs	40,899,555	3,283,969	6,162,373	50,345,897	5,963,644	495,903	250,533	57,055,978
MLTSS	33,096,069	2,642,467	363,816	36,102,353	1,254,384	59,105	34,850	37,450,691
Medical Management	2,232,979	1,511,832	295,793	4,040,604	1,103,023	29,526	836,903	6,010,056
Quality Incentives	894,005	449,017	140,263	1,483,285	195,410		5,000	1,683,695
Reinsurance & Other	54,251,414	38,683,119	31,206	92,965,739	195,623		196,399	93,357,761
Total Medical Expenses	213,552,147	119,356,106	22,075,468	354,983,721	24,341,258	1,816,176	2,762,170	383,903,326
Medical Loss Ratio	108.2%	78.1%	99.3%	95.3%	99.1%	116.0%	78.4%	95.4%
GROSS MARGIN	**(16,115,004)**	**33,524,921**	**159,164**	**17,569,081**	**231,936**	**(250,558)**	**762,730**	**18,313,188**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,720,461	753,261	75,825	142,914	7,692,461
Professional fees				200,988	4,000	15,000	123	220,112
Purchased services				931,229	81,189	8,823	4,820	1,026,061
Printing & Postage				278,531	70,817	5,200	23,156	377,704
Depreciation & Amortization				273,042			2,057	275,099
Other expenses				1,649,178	60,497	-	2,614	1,712,290
Indirect cost allocation & Occupancy				(353,405)	579,990	28,340	(53,336)	201,589
Total Administrative Expenses				9,700,025	1,549,755	133,188	122,348	11,505,316
Admin Loss Ratio				2.6%	6.3%	8.5%	3.5%	2.9%
INCOME (LOSS) FROM OPERATIONS				7,869,056	(1,317,820)	(383,747)	640,382	6,807,871
INVESTMENT INCOME								(476,268)
TOTAL MCO TAX				1,169,888				1,169,888
TOTAL GRANT INCOME				(47,663)				(47,663)
OTHER INCOME				50				50
CHANGE IN NET ASSETS				**$ 8,991,331**	**$ (1,317,820)**	**$ (383,747)**	**$ 640,382**	**$ 7,453,878**
BUDGETED CHANGE IN NET ASSETS				(1,967,723)	(1,327,322)	(117,763)	194,662	(1,968,146)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 10,959,053	$ 9,502	$ (265,984)	$ 445,720	$ 9,422,024

* Year-to-Date reclassification of prescription drug expense from Medi-Cal Expansion to Medi-Cal Classic

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Nine Months Ended March 31, 2020

	Medi-Cal Classic*	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	4,341,989	2,049,947	103,533	6,495,469	127,307	13,332	3,362	6,639,470
REVENUES								
Capitation Revenue	1,428,990,429	$ 1,026,843,471	$ 206,060,661	$ 2,661,894,561	$ 222,256,554	$ 15,372,629	$ 27,211,444	$ 2,926,735,188
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,428,990,429	1,026,843,471	206,060,661	2,661,894,561	222,256,554	15,372,629	27,211,444	2,926,735,188
MEDICAL EXPENSES								
Provider Capitation	349,160,189	393,943,944	90,242,437	833,346,571	98,879,547	4,309,216		936,535,334
Facilities	226,693,188	195,509,811	48,948,529	471,151,528	33,541,218	3,820,989	5,918,180	514,431,915
Professional Claims	161,739,331	63,915,929	13,278,163	238,933,422	6,804,523	466,410	5,064,571	251,268,926
Prescription Drugs	175,335,045	180,387,821	50,624,188	406,347,054	50,935,839	4,629,207	2,123,105	464,035,204
MLTSS	307,804,027	23,621,827	15,094,415	346,520,269	12,080,517	160,380	331,476	359,092,642
Medical Management	19,042,195	11,346,563	2,396,273	32,785,031	9,271,719	335,186	6,551,564	48,943,499
Quality Incentives	8,212,412	4,148,732	1,270,011	13,631,155	1,814,500		196,235	15,641,890
Reinsurance & Other	122,079,863	89,045,619	307,561	211,433,043	1,659,972		1,872,850	214,965,864
Total Medical Expenses	1,370,066,249	961,920,244	222,161,578	2,554,148,072	214,987,835	13,721,389	22,057,980	2,804,915,275
Medical Loss Ratio	95.9%	93.7%	107.8%	96.0%	96.7%	89.3%	81.1%	95.8%
GROSS MARGIN	**58,924,180**	**64,923,227**	**(16,100,917)**	**107,746,490**	**7,268,719**	**1,651,240**	**5,153,464**	**121,819,913**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				57,996,091	6,449,989	595,610	1,262,266	66,303,956
Professional fees				1,773,329	460,486	174,371	1,506	2,409,692
Purchased services				7,314,886	1,264,438	119,728	71,527	8,770,578
Printing & Postage				3,030,687	544,491	42,746	105,646	3,723,571
Depreciation & Amortization				3,006,362			18,714	3,025,075
Other expenses				13,187,130	281,948	2,237	35,160	13,506,475
Indirect cost allocation & Occupancy				(2,360,150)	5,028,550	347,805	38,749	3,054,954
Total Administrative Expenses				83,948,334	14,029,902	1,282,498	1,533,568	100,794,302
Admin Loss Ratio				3.2%	6.3%	8.3%	5.6%	3.4%
INCOME (LOSS) FROM OPERATIONS				23,798,156	(6,761,183)	368,742	3,619,896	21,025,611
INVESTMENT INCOME								29,194,355
TOTAL MCO TAX				(1,812,360)				(1,812,360)
TOTAL GRANT INCOME				(47,748)				(47,748)
OTHER INCOME				544				544
CHANGE IN NET ASSETS				**$ 21,938,591**	**$ (6,761,183)**	**$ 368,742**	**$ 3,619,896**	**$ 48,360,402**
BUDGETED CHANGE IN NET ASSETS				22,396,122	(11,510,726)	(998,822)	1,651,448	22,788,022
VARIANCE TO BUDGET - FAV (UNFAV)				$ (457,531)	$ 4,749,543	$ 1,367,564	$ 1,968,448	$ 25,572,380

* Year-to-Date reclassification of prescription drug expense from Medi-Cal Expansion to Medi-Cal Classic

March 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $7.5 million, $9.4 million favorable to budget
- Operating surplus is $6.8 million, with a surplus in non-operating income of $0.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $48.4 million, $25.6 million favorable to budget
- Operating surplus is $21.0 million, with a surplus in non-operating income of $27.3 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
7.9	(2.0)	9.8	Medi-Cal	23.8	22.4	1.4
(1.3)	(1.3)	0.0	OCC	(6.8)	(11.5)	4.7
(0.4)	(0.1)	(0.3)	OneCare	0.4	(1.0)	1.4
0.6	0.2	0.4	PACE	3.6	1.7	2.0
6.8	**(3.2)**	**10.0**	**Operating**	**21.0**	**11.5**	**9.5**
0.6	1.3	(0.6)	Inv./Rental Inc, MCO tax	27.3	11.3	16.1
0.6	**1.3**	**(0.6)**	**Non-Operating**	**27.3**	**11.3**	**16.1**
7.5	**(2.0)**	**9.4**	**TOTAL**	**48.4**	**22.8**	**25.6**

CalOptima - Consolidated
Enrollment Summary
For the Nine Months Ended March 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,242	66,241	1	0.0%	Aged	592,981	591,430	1,551	0.3%
502	615	(113)	(18.4%)	BCCTP	4,773	5,535	(762)	(13.8%)
45,109	43,587	1,522	3.5%	Disabled	402,888	393,538	9,350	2.4%
278,561	276,635	1,926	0.7%	TANF Child	2,536,630	2,538,817	(2,187)	(0.1%)
83,631	84,275	(644)	(0.8%)	TANF Adult	773,375	775,618	(2,243)	(0.3%)
3,519	3,404	115	3.4%	LTC	31,342	30,636	706	2.3%
224,582	235,744	(11,162)	(4.7%)	MCE	2,049,947	2,118,541	(68,594)	(3.2%)
11,162	12,940	(1,778)	(13.7%)	WCM	103,533	116,460	(12,927)	(11.1%)
713,308	**723,441**	**(10,133)**	**(1.4%)**	**Medi-Cal Total**	**6,495,470**	**6,570,575**	**(75,105)**	**(1.1%)**
14,077	**13,897**	**180**	**1.3%**	**OneCare Connect**	**127,307**	**126,500**	**807**	**0.6%**
1,364	**1,513**	**(149)**	**(9.8%)**	**OneCare**	**13,332**	**13,529**	**(197)**	**(1.5%)**
400	**403**	**(3)**	**(0.7%)**	**PACE**	**3,362**	**3,337**	**25**	**0.7%**
729,149	**739,254**	**(10,105)**	**(1.4%)**	**CalOptima Total**	**6,639,471**	**6,713,941**	**(74,470)**	**(1.1%)**
				Enrollment (by Network)				
157,479	160,598	(3,119)	(1.9%)	HMO	1,431,167	1,457,896	(26,729)	(1.8%)
203,159	205,743	(2,584)	(1.3%)	PHC	1,849,881	1,878,397	(28,516)	(1.5%)
167,982	185,143	(17,161)	(9.3%)	Shared Risk Group	1,585,930	1,683,144	(97,214)	(5.8%)
184,688	171,957	12,731	7.4%	Fee for Service	1,628,491	1,551,138	77,353	5.0%
713,308	**723,441**	**(10,133)**	**(1.4%)**	**Medi-Cal Total**	**6,495,470**	**6,570,575**	**(75,105)**	**(1.1%)**
14,077	**13,897**	**180**	**1.3%**	**OneCare Connect**	**127,307**	**126,500**	**807**	**0.6%**
1,364	**1,513**	**(149)**	**(9.8%)**	**OneCare**	**13,332**	**13,529**	**(197)**	**(1.5%)**
400	**403**	**(3)**	**(0.7%)**	**PACE**	**3,362**	**3,337**	**25**	**0.7%**
729,149	**739,254**	**(10,105)**	**(1.4%)**	**CalOptima Total**	**6,639,471**	**6,713,941**	**(74,470)**	**(1.1%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD Actual	YTD Budget	Variance
HMOs												
Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	3,625	3,679	33,680	34,162	(482)
BCCTP	1	1	2	2	1	1	1	1	1	11	9	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	6,612	6,670	59,200	59,593	(393)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	50,743	51,816	471,307	474,104	(2,797)
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	25,208	25,961	240,862	248,895	(8,033)
LTC	2	1	3	3	2	4		5	1	21	18	3
MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	66,229	67,457	608,381	619,848	(11,467)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	1,937	1,894	17,705	21,267	(3,562)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**150,328**	**154,360**	**157,479**	**1,431,167**	**1,457,896**	**(26,729)**
PHCs												
Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	1,448	1,474	13,748	13,704	44
BCCTP										-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	5,422	5,436	48,739	47,975	764
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	140,195	142,951	1,300,130	1,316,888	(16,758)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	9,907	10,366	96,359	91,500	4,859
LTC			1		1	1	2	2	1	8		8
MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	35,640	36,168	328,070	339,174	(11,104)
WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	6,803	6,763	62,827	69,156	(6,329)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**200,479**	**199,417**	**203,159**	**1,849,881**	**1,878,397**	**(28,516)**
Shared Risk Groups												
Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	3,225	3,223	30,703	32,627	(1,924)
BCCTP						1	(1)	1		1		1
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	7,092	7,010	64,055	61,231	2,824
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	54,614	55,822	524,657	552,341	(27,684)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	24,861	25,641	241,531	255,754	(14,223)
LTC	1	3	3	2	1	1		1	1	13	9	4
MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	73,826	74,815	710,846	763,479	(52,633)
WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	1,457	1,470	14,124	17,703	(3,579)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**162,009**	**165,077**	**167,982**	**1,585,930**	**1,683,144**	**(97,214)**
Fee for Service (Dual)												
Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	52,919	52,855	473,235	470,210	3,025
BCCTP	15	18	17	18	19	20	13	10	12	142	162	(20)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	20,729	21,085	186,397	184,685	1,712
TANF Child		19	1	1	1	1	1	1	1	26		26
TANF Adult	964	1,923	949	941	963	938	1,528	917	847	9,970	7,928	2,042
LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	3,142	3,157	28,226	27,441	785
MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	1,084	1,135	15,026	18,585	(3,559)
WCM	15	15	15	16	15	16	15	14	13	134	144	(10)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**81,519**	**78,816**	**79,105**	**713,156**	**709,155**	**4,001**
Fee for Service (Non-Dual - Total)												
Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	5,163	5,011	41,615	40,727	888
BCCTP	550	542	484	532	525	518	506	473	489	4,619	5,364	(745)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	5,084	4,908	44,497	40,054	4,443
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	29,586	27,971	240,510	195,484	45,026
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	18,203	21,106	20,816	184,653	171,541	13,112
LTC	328	326	331	347	364	302	358	359	359	3,074	3,168	(94)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	44,795	45,007	387,624	377,455	10,169
WCM	843	960	978	1,008	1,079	874	936	1,043	1,022	8,743	8,190	553
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**95,306**	**107,609**	**105,583**	**915,335**	**841,983**	**73,352**
Grand Totals												
Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	66,380	66,242	592,981	591,430	1,551
BCCTP	566	561	503	552	545	540	519	485	502	4,773	5,535	(762)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	44,939	45,109	402,888	393,538	9,350
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	275,139	278,561	2,536,630	2,538,817	(2,187)
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	81,999	83,631	773,375	775,618	(2,243)
LTC	3,375	3,427	3,399	3,513	3,572	3,279	3,749	3,509	3,519	31,342	30,636	706
MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	221,574	224,582	2,049,947	2,118,541	(68,594)
WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	11,254	11,162	103,533	116,460	(12,927)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,412**	**689,641**	**705,279**	**713,308**	**6,495,470**	**6,570,575**	**(75,105)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**14,104**	**14,171**	**14,077**	**127,307**	**126,500**	**807**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**1,417**	**1,382**	**1,364**	**13,332**	**13,529**	**(197)**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**394**	**396**	**400**	**3,362**	**3,337**	**25**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,534**	**705,556**	**721,228**	**729,149**	**6,639,471**	**6,713,941**	**(74,470)**

ENROLLMENT:

Overall March enrollment was 729,149

- Unfavorable to budget 10,105 or 1.4%
- Increased 7,921 or 1.1% from prior month (PM) (February 2020)
- Decreased 38,130 or 5.0% from prior year (PY) (March 2019)

Medi-Cal enrollment was 713,308

- Unfavorable to budget 10,133 or 1.4%
  - Medi-Cal Expansion (MCE) unfavorable 11,162
  - Whole Child Model (WCM) unfavorable 1,778
  - Seniors and Persons with Disabilities (SPD) favorable 1,410
  - Temporary Assistance for Needy Families (TANF) favorable 1,282
  - Long-Term Care (LTC) favorable 115
- Increased 8,029 from PM

OneCare Connect enrollment was 14,077

- Favorable to budget 180 or 1.3%
- Decreased 94 from PM

OneCare enrollment was 1,364

- Unfavorable to budget 149 or 9.8%
- Decreased 18 from PM

PACE enrollment was 400

- Unfavorable to budget 3 or 0.7%
- Increased 4 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
713,308	**723,441**	**(10,133)**	**(1.4%)**	**Member Months**	**6,495,470**	**6,570,575**	**(75,105)**	**(1.1%)**
				Revenues				
372,552,802	268,347,082	104,205,719	38.8%	Capitation Revenue	2,661,894,561	2,419,477,695	242,416,866	10.0%
-	-	-	0.0%	Other Income	-	-	-	0.0%
372,552,802	**268,347,082**	**104,205,719**	**38.8%**	**Total Operating Revenue**	**2,661,894,561**	**2,419,477,695**	**242,416,866**	**10.0%**
				Medical Expenses				
91,108,819	95,021,988	3,913,169	4.1%	Provider Capitation	846,977,726	855,967,713	8,989,987	1.1%
50,592,583	49,082,532	(1,510,051)	(3.1%)	Facilities Claims	471,151,528	434,716,769	(36,434,759)	(8.4%)
29,827,726	23,640,030	(6,187,696)	(26.2%)	Professional Claims	238,933,422	208,092,278	(30,841,144)	(14.8%)
50,345,897	44,561,605	(5,784,293)	(13.0%)	Prescription Drugs	406,347,054	395,469,483	(10,877,571)	(2.8%)
36,102,353	37,780,414	1,678,061	4.4%	MLTSS	346,520,269	333,632,341	(12,887,928)	(3.9%)
4,040,604	5,507,993	1,467,389	26.6%	Medical Management	32,785,031	42,687,499	9,902,468	23.2%
92,965,739	3,229,841	(89,735,898)	(2778.3%)	Reinsurance & Other	211,433,043	28,826,341	(182,606,702)	(633.5%)
354,983,721	**258,824,402**	**(96,159,319)**	**(37.2%)**	**Total Medical Expenses**	**2,554,148,072**	**2,299,392,424**	**(254,755,648)**	**(11.1%)**
17,569,081	**9,522,680**	**8,046,400**	**84.5%**	**Gross Margin**	**107,746,490**	**120,085,271**	**(12,338,782)**	**(10.3%)**
				Administrative Expenses				
6,720,461	7,424,257	703,796	9.5%	Salaries, Wages & Employee Benefits	57,996,091	64,010,288	6,014,197	9.4%
200,988	399,574	198,586	49.7%	Professional Fees	1,773,329	3,405,120	1,631,791	47.9%
931,229	1,353,004	421,775	31.2%	Purchased Services	7,314,886	8,990,030	1,675,144	18.6%
278,531	392,911	114,380	29.1%	Printing and Postage	3,030,687	3,942,155	911,468	23.1%
273,042	455,750	182,708	40.1%	Depreciation & Amortization	3,006,362	4,101,750	1,095,388	26.7%
1,649,178	1,646,653	(2,525)	(0.2%)	Other Operating Expenses	13,187,130	14,831,443	1,644,313	11.1%
(353,405)	(181,746)	171,659	94.4%	Indirect Cost Allocation, Occupancy Expense	(2,360,150)	(1,591,637)	768,513	48.3%
9,700,025	**11,490,403**	**1,790,378**	**15.6%**	**Total Administrative Expenses**	**83,948,334**	**97,689,149**	**13,740,815**	**14.1%**
				Operating Tax				
(76,134,052)	11,156,172	(87,290,224)	(782.4%)	Tax Revenue	33,946,475	101,308,581	(67,362,106)	(66.5%)
(77,303,939)	11,156,172	88,460,111	792.9%	Premium Tax Expense	35,758,834	101,308,581	65,549,747	64.7%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
1,169,888	-	1,169,888	**0.0%**	**Total Net Operating Tax**	(1,812,360)	-	(1,812,360)	**0.0%**
				Grant Income				
52,340	-	52,340	0.0%	Grant Revenue	152,532	-	152,532	0.0%
91,913	-	(91,913)	0.0%	Grant expense - Service Partner	107,425	-	(107,425)	0.0%
8,090	-	(8,090)	0.0%	Grant expense - Administrative	92,855	-	(92,855)	0.0%
(47,663)	-	(47,663)	**0.0%**	**Total Grant Income**	(47,748)	-	(47,748)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**0**	**-**	**0**	**0.0%**
50	**-**	**50**	**0.0%**	**Other income**	**544**	**-**	**544**	**0.0%**
8,991,331	**(1,967,723)**	**10,959,053**	**556.9%**	**Change in Net Assets**	**21,938,591**	**22,396,122**	**(457,531)**	**(2.0%)**
95.3%	***96.5%***	***1.2%***	***1.2%***	***Medical Loss Ratio***	***96.0%***	***95.0%***	***(0.9%)***	***(1.0%)***
2.6%	***4.3%***	***1.7%***	***39.2%***	***Admin Loss Ratio***	***3.2%***	***4.0%***	***0.9%***	***21.9%***

MEDI-CAL INCOME STATEMENT – MARCH MONTH:

REVENUES of $372.6 million are favorable to budget $104.2 million driven by:

- Unfavorable volume related variance of $3.8 million
- Favorable price related variance of $108.0 million due to:
  - $91.0 million of Directed Payment (DP) revenue
  - $14.4 million of acuity rate adjustment and updated MCE rates from the Department of Health Care Services (DHCS)
  - $1.6 million of LTC revenue from non-LTC categories of aid
  - $1.5 million of Behavioral Health Treatment (BHT) revenue
  - Offset by $3.3 million of WCM revenue

MEDICAL EXPENSES of $355.0 million are unfavorable to budget $96.2 million driven by:

- Favorable volume related variance of $3.6 million
- Unfavorable price related variance of $99.8 million due to:
  - Reinsurance & Other expenses unfavorable variance of $89.8 million due to DP
  - Professional Claims unfavorable variance of $6.5 million due to crossover claims
  - Prescription Drugs unfavorable variance of $6.4 million due to increased utilization
  - Provider Capitation favorable variance of $2.6 million

ADMINISTRATIVE EXPENSES of $9.7 million are favorable to budget $1.8 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.7 million
- Other Non-Salary expenses are favorable to budget $1.1 million

CHANGE IN NET ASSETS is $9.0 million for the month, favorable to budget $11.0 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Nine Months Ending March 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,077	**13,897**	**180**	**1.3%**	**Member Months**	**127,307**	**126,500**	**807**	**0.6%**
				Revenues				
2,630,263	2,725,395	(95,132)	(3.5%)	Medi-Cal Capitation Revenue	22,352,001	24,928,303	(2,576,302)	(10.3%)
16,756,787	16,543,637	213,150	1.3%	Medicare Capitation Revenue Part C	151,548,615	147,048,901	4,499,714	3.1%
5,186,144	4,810,169	375,975	7.8%	Medicare Capitation Revenue Part D	48,355,938	43,165,219	5,190,719	12.0%
-	-	-	0.0%	Other Income	-	-	-	0.0%
24,573,194	**24,079,201**	**493,993**	**2.1%**	**Total Operating Revenue**	**222,256,554**	**215,142,423**	**7,114,131**	**3.3%**
				Medical Expenses				
11,153,439	10,924,783	(228,656)	(2.1%)	Provider Capitation	100,694,047	98,344,864	(2,349,183)	(2.4%)
3,918,192	3,585,966	(332,226)	(9.3%)	Facilities Claims	33,541,218	31,559,032	(1,982,186)	(6.3%)
752,954	710,602	(42,352)	(6.0%)	Ancillary	6,804,523	6,170,640	(633,883)	(10.3%)
1,254,384	1,539,115	284,731	18.5%	MLTSS	12,080,517	13,871,156	1,790,639	12.9%
5,963,644	5,462,161	(501,483)	(9.2%)	Prescription Drugs	50,935,839	48,483,288	(2,452,551)	(5.1%)
1,103,023	1,185,578	82,555	7.0%	Medical Management	9,271,719	10,059,542	787,823	7.8%
195,623	221,772	26,149	11.8%	Other Medical Expenses	1,659,972	1,967,661	307,689	15.6%
24,341,258	**23,629,977**	**(711,281)**	**(3.0%)**	**Total Medical Expenses**	**214,987,835**	**210,456,183**	**(4,531,652)**	**(2.2%)**
231,936	**449,224**	**(217,288)**	**(48.4%)**	**Gross Margin**	**7,268,719**	**4,686,240**	**2,582,479**	**55.1%**
				Administrative Expenses				
753,261	868,220	114,959	13.2%	Salaries, Wages & Employee Benefits	6,449,989	7,422,039	972,050	13.1%
4,000	77,796	73,796	94.9%	Professional Fees	460,486	700,163	239,677	34.2%
81,189	142,988	61,799	43.2%	Purchased Services	1,264,438	1,886,898	622,460	33.0%
70,817	95,861	25,044	26.1%	Printing and Postage	544,491	862,743	318,252	36.9%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
60,497	71,889	11,392	15.8%	Other Operating Expenses	281,948	646,995	365,047	56.4%
579,990	519,792	(60,198)	(11.6%)	Indirect Cost Allocation	5,028,550	4,678,128	(350,422)	(7.5%)
1,549,755	**1,776,546**	**226,791**	**12.8%**	**Total Administrative Expenses**	**14,029,902**	**16,196,966**	**2,167,064**	**13.4%**
				Operating Tax				
-	-	-	0.0%	Tax Revenue	-	-	-	0.0%
-	-	-	0.0%	Premium Tax Expense	-	-	-	0.0%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
(1,317,820)	**(1,327,322)**	**9,502**	**0.7%**	**Change in Net Assets**	**(6,761,183)**	**(11,510,726)**	**4,749,543**	**41.3%**
99.1%	***98.1%***	***(0.9%)***	***(0.9%)***	***Medical Loss Ratio***	***96.7%***	***97.8%***	***1.1%***	***1.1%***
6.3%	***7.4%***	***1.1%***	***14.5%***	***Admin Loss Ratio***	***6.3%***	***7.5%***	***1.2%***	***16.2%***

ONECARE CONNECT INCOME STATEMENT– MARCH MONTH:

REVENUES of $24.6 million are favorable to budget $0.5 million driven by:

- Favorable volume related variance of $0.3 million
- Favorable price related variance of $0.2 million

MEDICAL EXPENSES of $24.3 million are unfavorable to budget $0.7 million driven by:

- Unfavorable volume related variance of $0.3 million
- Unfavorable price related variance of $0.4 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($1.3) million, in line with budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,364	**1,513**	**(149)**	**(9.8%)**	**Member Months**	**13,332**	**13,529**	**(197)**	**(1.5%)**
				Revenues				
1,188,961	1,129,202	59,759	5.3%	Medicare Part C revenue	10,920,939	10,066,458	854,481	8.5%
376,657	524,046	(147,389)	(28.1%)	Medicare Part D revenue	4,451,690	4,680,522	(228,832)	(4.9%)
1,565,618	**1,653,248**	**(87,630)**	**(5.3%)**	**Total Operating Revenue**	**15,372,629**	**14,746,980**	**625,649**	**4.2%**
				Medical Expenses				
466,521	437,349	(29,172)	(6.7%)	Provider Capitation	4,309,216	3,958,600	(350,616)	(8.9%)
688,741	515,585	(173,156)	(33.6%)	Inpatient	3,820,989	4,543,121	722,132	15.9%
76,380	56,292	(20,088)	(35.7%)	Ancillary	466,410	496,261	29,851	6.0%
59,105	46,254	(12,851)	(27.8%)	Skilled Nursing Facilities	160,380	407,657	247,277	60.7%
495,903	506,505	10,602	2.1%	Prescription Drugs	4,629,207	4,487,712	(141,495)	(3.2%)
29,526	49,151	19,625	39.9%	Medical Management	335,186	431,061	95,875	22.2%
-	10,920	10,920	100.0%	Other Medical Expenses	-	97,645	97,645	100.0%
1,816,176	**1,622,056**	**(194,120)**	**(12.0%)**	**Total Medical Expenses**	**13,721,389**	**14,422,057**	**700,668**	**4.9%**
(250,558)	**31,192**	**(281,750)**	**(903.3%)**	**Gross Margin**	**1,651,240**	**324,923**	**1,326,317**	**408.2%**
				Administrative Expenses				
75,825	53,418	(22,407)	(41.9%)	Salaries, wages & employee benefits	595,610	463,912	(131,698)	(28.4%)
15,000	21,480	6,480	30.2%	Professional fees	174,371	193,320	18,949	9.8%
8,823	17,063	8,240	48.3%	Purchased services	119,728	153,567	33,839	22.0%
5,200	16,667	11,467	68.8%	Printing and postage	42,746	150,003	107,257	71.5%
-	4,738	4,738	100.0%	Other operating expenses	2,237	42,642	40,405	94.8%
28,340	35,589	7,249	20.4%	Indirect cost allocation, occupancy expense	347,805	320,301	(27,504)	(8.6%)
133,188	**148,955**	**15,767**	**10.6%**	**Total Administrative Expenses**	**1,282,498**	**1,323,745**	**41,247**	**3.1%**
(383,747)	**(117,763)**	**(265,984)**	**(225.9%)**	**Change in Net Assets**	**368,742**	**(998,822)**	**1,367,564**	**136.9%**
116.0%	***98.1%***	***(17.9%)***	***(18.2%)***	***Medical Loss Ratio***	***89.3%***	***97.8%***	***8.5%***	***8.7%***
8.5%	***9.0%***	***0.5%***	***5.6%***	***Admin Loss Ratio***	***8.3%***	***9.0%***	***0.6%***	***7.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
400	**403**	**(3)**	**(0.7%)**	**Member Months**	**3,362**	**3,337**	**25**	**0.7%**
				Revenues				
2,817,127	2,421,941	395,186	16.3%	Medi-Cal Capitation Revenue	21,321,374	20,062,637	1,258,737	6.3%
554,798	551,474	3,324	0.6%	Medicare Part C Revenue	4,651,645	4,621,701	29,944	0.6%
152,975	148,870	4,105	2.8%	Medicare Part D Revenue	1,238,425	1,231,054	7,371	0.6%
3,524,900	**3,122,285**	**402,615**	**12.9%**	**Total Operating Revenue**	**27,211,444**	**25,915,392**	**1,296,052**	**5.0%**
				Medical Expenses				
836,903	909,769	72,866	8.0%	Medical Management	6,551,564	7,885,247	1,333,683	16.9%
672,112	603,026	(69,086)	(11.5%)	Facilities Claims	5,918,180	4,886,537	(1,031,643)	(21.1%)
766,374	658,920	(107,454)	(16.3%)	Professional Claims	5,064,571	5,353,917	289,346	5.4%
196,399	272,113	75,714	27.8%	Patient Transportation	1,872,850	2,153,063	280,213	13.0%
250,533	251,423	890	0.4%	Prescription Drugs	2,123,105	2,037,660	(85,445)	(4.2%)
34,850	37,249	2,399	6.4%	MLTSS	331,476	244,478	(86,998)	(35.6%)
5,000	6,666	1,666	25.0%	Other Expenses	196,235	60,000	(136,235)	(227.1%)
2,762,170	**2,739,166**	**(23,004)**	**(0.8%)**	**Total Medical Expenses**	**22,057,980**	**22,620,902**	**562,922**	**2.5%**
762,730	**383,119**	**379,611**	**99.1%**	**Gross Margin**	**5,153,464**	**3,294,490**	**1,858,974**	**56.4%**
				Administrative Expenses				
142,914	148,297	5,383	3.6%	Salaries, wages & employee benefits	1,262,266	1,283,378	21,112	1.6%
123	153	30	19.4%	Professional fees	1,506	1,377	(129)	(9.4%)
4,820	18,971	14,151	74.6%	Purchased services	71,527	170,739	99,212	58.1%
23,156	10,533	(12,623)	(119.8%)	Printing and postage	105,646	94,797	(10,849)	(11.4%)
2,057	2,116	59	2.8%	Depreciation & amortization	18,714	19,044	330	1.7%
2,614	4,137	1,523	36.8%	Other operating expenses	35,160	37,223	2,063	5.5%
(53,336)	4,250	57,586	1355.0%	Indirect Cost Allocation, Occupancy Expense	38,749	36,484	(2,265)	(6.2%)
122,348	**188,457**	**66,110**	**35.1%**	**Total Administrative Expenses**	**1,533,568**	**1,643,042**	**109,474**	**6.7%**
				Operating Tax				
(26,296)	-	(26,296)	0.0%	Tax Revenue	17,660	-	17,660	0.0%
(26,296)	-	26,296	0.0%	Premium Tax Expense	17,660	-	(17,660)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
640,382	**194,662**	**445,720**	**229.0%**	**Change in Net Assets**	**3,619,896**	**1,651,448**	**1,968,448**	**119.2%**
78.4%	***87.7%***	***9.4%***	***10.7%***	***Medical Loss Ratio***	***81.1%***	***87.3%***	***6.2%***	***7.1%***
3.5%	***6.0%***	***2.6%***	***42.5%***	***Admin Loss Ratio***	***5.6%***	***6.3%***	***0.7%***	***11.1%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2020

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				
46,343	23,101	(23,242)	(100.6%)	Purchase services	433,635	207,910	(225,725)	(108.6%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	1,480,444	1,572,525	92,081	5.9%
17,477	15,866	(1,611)	(10.2%)	Insurance expense	157,288	142,794	(14,494)	(10.2%)
73,167	140,162	66,995	47.8%	Repair and maintenance	896,041	1,261,458	365,417	29.0%
27,271	46,432	19,161	41.3%	Other Operating Expense	378,315	417,888	39,573	9.5%
(328,751)	(400,286)	(71,535)	(17.9%)	Indirect allocation, Occupancy	(3,345,724)	(3,602,575)	(256,851)	(7.1%)
0	**-**	**(0)**	**0.0%**	**Total Administrative Expenses**	**(0)**	**-**	**0**	**0.0%**
(0)	**-**	**(0)**	**0.0%**	**Change in Net Assets**	**0**	**-**	**0**	**0.0%**

OTHER INCOME STATEMENTS – MARCH MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($383.7) thousand, unfavorable to budget $266.0 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $640.4 thousand, favorable to budget $445.7 thousand

CalOptima
Balance Sheet
March 31, 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$382,898,813	Accounts Payable	$41,752,651
Investments	518,455,688	Medical Claims liability	781,885,602
Capitation receivable	387,689,990	Accrued Payroll Liabilities	13,997,455
Receivables - Other	51,102,708	Deferred Revenue	30,787,390
Prepaid expenses	6,893,911	Deferred Lease Obligations	170,710
		Capitation and Withholds	132,250,984
Total Current Assets	**1,347,041,111**	**Total Current Liabilities**	**1,000,844,794**
Capital Assets			
Furniture & Equipment	37,266,060		
Building/Leasehold Improvements	11,736,817		
505 City Parkway West	50,489,717		
	99,492,593		
Less: accumulated depreciation	(51,440,146)		
Capital assets, net	48,052,447	Other (than pensions) post	
		employment benefits liability	25,821,090
Other Assets		Net Pension Liabilities	23,529,538
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,050,195,422**
Cash and Cash Equivalents	7,610,600		
Long-term Investments	569,212,008	Deferred Inflows	
Total Board-designated Assets	576,822,608	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	635,321,521	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,030,415,079**	TNE	100,958,386
		Funds in Excess of TNE	882,944,885
Deferred Outflows		**TOTAL NET POSITION**	983,903,272
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,041,505,528**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,041,505,528**

CalOptima
Board Designated Reserve and TNE Analysis
as of March 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	157,864,886				
	Tier 1 - Logan Circle	156,881,532				
	Tier 1 - Wells Capital	157,161,784				
Board-designated Reserve		471,908,201	320,551,041	501,197,938	151,357,160	(29,289,737)
TNE Requirement	Tier 2 - Logan Circle	104,914,407	100,958,386	100,958,386	3,956,021	3,956,021
	Consolidated:	**576,822,608**	**421,509,427**	**602,156,324**	**155,313,181**	**(25,333,716)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
March 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	7,453,878	48,360,402
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	439,593	4,505,520
Changes in assets and liabilities:		
Prepaid expenses and other	674,119	(1,106,170)
Catastrophic reserves		
Capitation receivable	28,331,814	(86,850,931)
Medical claims liability	(131,337,538)	29,574,651
Deferred revenue	(23,238,576)	(20,247,373)
Payable to health networks	3,485,663	23,347,844
Accounts payable	(76,472,206)	(914,075)
Accrued payroll	968,416	4,033,546
Other accrued liabilities	-	126,198
Net cash provided by/(used in) operating activities	(189,694,838)	829,612
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	85,071,297	55,250,608
Change in Property and Equipment	(521,179)	(5,933,077)
Change in Board designated reserves	(1,201,767)	(16,677,201)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	83,348,351	34,441,417
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(106,346,487)	35,271,029
CASH AND CASH EQUIVALENTS, beginning of period	$489,245,301	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**382,898,813**	**382,898,813**

BALANCE SHEET – MARCH MONTH:

ASSETS of $2.0 billion decreased $219.1 million from February or 9.7%

- Operating Cash decreased $106.3 million due to the disbursement of Hospital Quality Assurance Fee (HQAF) funding
- Investments decreased $85.1 million due to HQAF funding disbursement
- Capitation Receivables decreased $44.1 million due to timing of capitation received
- Receivables – Other increased $15.7 million due to reclassification of sales tax overpayment

LIABILITIES of $1.1 billion decreased $226.6 million from February or 17.7%

- Claims Liabilities decreased $131.3 million due to disbursement of DP and reclassification of sales tax overpayment
- Accounts Payable decreased $76.5 million due to release of Managed Care Organization (MCO) tax accruals
- Capitation and Withhold increased $3.5 million due to timing of capitation payments

NET ASSETS total $983.9 million

Homeless Health Initiative and Allocated Funds
as of March 31, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,500,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC - Expansion	570,000	
Funds Allocation Total		41,801,087
Program Commitment Balance, available for new initiatives:		$58,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for March 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Human Resources Corporate Application)
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.

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
May 7, 2020

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- CY2018 Medicare Part D Prescription Drug Event Validation (OneCare and OneCare Connect):

  On January 10, 2020, CMS informed CalOptima that its OneCare and OneCare Connect programs have been selected to participate in the Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (PEPV) audit.

  CMS conducts the audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2018 payments. CMS released the contract-specific documentation for both programs on January 24, 2020. CalOptima submitted supporting documentation for this audit on February 20, 2020. On February 25, 2020, CMS provided preliminary findings that the documentation has been accepted. No additional submissions are required at this time.

  On April 2, 2020, in light of the current public health crisis, CMS directed plans to cease making requests for documentation from providers regarding the CY 2018 PEPV audit. CMS will make an announcement when audit activities resume.

- Calendar Year (CY) 2015 Medicare Part C Contract-level Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit and requested the submission of medical record documentation by July 10, 2020.

  On March 30, 2020, in light of the current public health crisis, CMS suspended CY 2015 RADV audit activities and directed plans to cease making requests for documentation from

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providers immediately. CMS will make an announcement when audit activities resume. In the meantime, CMS will continue to review and provide feedback on medical records already submitted to CMS.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to conduct a Medicare Data Validation (MDV) audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent auditor, Advent, was held on January 6, 2020. Historically, the data validation audit season takes place from March through June each year. The audit includes a webinar validation and source documentation review of Medicare Parts C and D reporting data submitted for the prior calendar year.

  On April 13, 2020, in light of the current public health crisis, CMS informed plans that they will focus their validation efforts on the following Parts C and D measures only:

  - Part C Special Needs Plans (SNPs) Care Management
  - Part D Medication Therapy Management (MTM) Programs

  The following Parts C and D measures will not be validated during the 2020 MDV audit, but will still be used by CMS for monitoring purposes:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Improving Drug Utilization Review (IDUR) Controls

  CalOptima's audit has been scheduled for April 22, 2020.

2. OneCare Connect

- National 2018 Risk Adjustment Data Validation (RADV) Audit:

  On January 13, 2020, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement, known as the National Risk Adjustment Data Validation (RADV) audit. CMS will be conducting medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C. On February 14, 2020, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with three (3) hierarchical condition categories (HCCs) was selected for validation. The final deadline for submission of medical records to CMS is June 8, 2020. On March 23, 2020, CalOptima submitted medical records for all three (3) HCCs and is pending CMS' review and release of the interim findings.

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On April 13, 2020, CMS provided preliminary results, which indicated that the sampled HCCs were found within the medical records submitted and that no further action is required from CalOptima at this time.

3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  The Department of Health Care Services' (DHCS) onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of February 1, 2019 to January 31, 2020 and pertained to CalOptima's Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

  On February 12, the state notified CalOptima that, in response to a request from DHCS leadership, it planned to add to the Medi-Cal audit scope by reviewing authorization practices related to post-stabilization care. In addition to auditing CalOptima's practices, the DHCS indicated that it will also examine the practices of two (2) CalOptima delegates, Prospect Medical Group and Family Choice Medical Group. The interviews for this portion of the audit scope have been delayed due to the current public health crisis. Date(s) for the interviews have not been scheduled yet.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which focused on the accuracy and completeness of CY 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

  On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the near future. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the month of March 2020.

3 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%
January 2020	100%	100%	100%	100%

➢ For the January 2020 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 100% for timely processing of claims based on a focused review of sixty (60) claims.

➢ Based on the overall universe of Medi-Cal claims for January 2020, CalOptima's Claims department received an overall compliance score of 99.53% for timely processing of claims.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
November 2019	98%	100%	93%	100%	98%
December 2019	97%	100%	100%	100%	100%
January 2020	98%	85%	100%	100%	Nothing to Report

➢ For the January 2020 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 95.75% for timely processing of PDRs based on a focused review of forty (40) PDRs.

➢ Based on the overall universe of Medi-Cal PDRs for January 2020, CalOptima's Claims department received an overall compliance score of 100% for timely processing of PDRs.

➢ The lower compliance score of 85% for PDRs for January 2020 was due to untimely resolution of multiple PDRs.

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- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of PDRs within regulatory requirements.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	100%	100%	100%	60%
December 2019	100%	100%	100%	80%
January 2020	93.33%	86.67%	100%	86.67%

- For the January 2020 file review of OneCare claims, CalOptima's Claims department received a compliance score of 91.67% for timely processing of claims based on a focused review of thirty (30) paid and denied claims selected for review.

- Based on the overall universe of OneCare claims for January 2020, CalOptima's Claims department received an overall compliance score of 98.94% for timely processing of claims.

- The lower compliance score of 86.67% for paid claims accuracy for January 2020 was due to two (2) inaccurate claims.

- The lower compliance score of 86.67% for denied claims accuracy for January 2020 was due to two (2) inaccurate claims.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

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- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
November 2019	100%	100%	100%
December 2019	100%	100%	100%
January 2020	100%	100%	100%

- For the January 2020 file review of OneCare PDRs, CalOptima's Claims department received a compliance score of 100% for timely processing of PDRs based on a focused review of two (2) PDRs selected for review.

- Based on the overall universe of OneCare PDRs for January 2020, CalOptima's Claims department received an overall compliance score of 100% for timely processing of PDRs.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%
January 2020	100%	100%	100%	100%

- For the January 2020 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 100% for timely processing of claims based on a focused review of thirty (30) paid and denied claims selected for review.

- Based on the overall universe of OneCare Connect claims for January 2020, CalOptima's Claims department received an overall compliance score of 99.01% for timely processing of claims.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
November 2019	95%	100%	100%
December 2019	100%	100%	100%
January 2020	100%	95%	100%

- For the January 2020 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 98.33% for timely processing of PDRs based on a focused review of twenty (20) PDRs selected for review.

- Based on the overall universe of OneCare Connect PDRs for January 2020, CalOptima's Claims department received an overall compliance score of 100% for timely processing of PDRs.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
November 2019	100%	100%	100%	100%
December 2019	100%	100%	100%	100%
January 2020	100%	100%	100%	100%

- For the January 2020 file review of PACE claims, CalOptima's Claims department received a compliance score of 100% for timely processing of claims based on a focused review of thirty (30) paid and denied claims selected for review.

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- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
November 2019	100%	100%	100%	N/A
December 2019	100%	100%	100%	N/A
January 2020	100%	100%	100%	N/A

  - For the January 2020 file review of PACE PDRs, CalOptima's Claims department received a score of 100% for timely processing of PDRs based on a focused review of fourteen (14) PDRs selected for review.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
November 2019	0%	100%
December 2019	Nothing to Report	100%
January 2020	0%	100%

  - For the January 2020 file review of PACE SDRs, CalOptima's PACE department received a score of 50% for timely processing of SDRs based on a focused review of four (4) SDRs selected for review.

  - Based on the overall universe of PACE SDRs for January 2020, CalOptima's PACE department received an overall compliance score of 100% for timely processing of SDRs.

  - The lower compliance score of 0% for SDR denials for January 2020 was due to missing documentation based on a review of one (1) SDR.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of SDRs. The A&O department continues to work with the PACE department to remediate the

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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 SDRs within regulatory requirements.

5. Internal Auditing: Grievances and Appeals (Medi-Cal, OneCare, and OneCare Connect) [a\]

- CalOptima's Audit & Oversight (Internal) Department performed an internal audit of appeals and grievances for the Medi-Cal, OneCare, and OneCare Connect lines of business in December 2019. The audit covered the review period of April 1, 2019 through August 31, 2019. The audit areas included:

  - Medi-Cal Standard / Expedited Grievances
  - Medi-Cal Standard / Expedited Appeals
  - Organization Determinations, Appeals and Grievances (ODAG)
  - Medicare-Medicaid Plan (MMP) Service Authorizations Requests, Appeals and Grievances (SARAG)
  - Part D Coverage Determinations, Appeals and Grievances (CDAG)

- Medi-Cal Grievances and Appeals:

Audit Area	Timeliness	Member / Provider Notifications
Standard Grievances	100%	100%
Expedited Grievances	100%	60%
Standard and Expedited Medical Appeals	90%	70%

  - For standard grievances, CalOptima's Grievance & Appeals Resolution Services (GARS) department received a score of 100% for timeliness and member / provider notifications based on a focused review of ten (10) standard grievances selected for review.

  - For expedited grievances, the lower compliance score of 60% for member / provider notifications was due to four (4) case resolution letters that did not address all of the members' grievances.

  - For standard and expedited medical appeals, the lower compliance score for member / provider notifications was due to the following:
    – Resolution letter did not include the member's state hearing rights
    – No medical citation was documented in the Medical Director's decision and resolution letter

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– Resolution letter did not address all of the member's appeal requests

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of Medi-Cal grievances and 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 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 grievances and appeals within regulatory requirements.

- OneCare Coverage Determinations, Appeals, and Grievances (CDAG):

Audit Area	Timeliness	Member / Provider Notifications
Direct Member Reimbursement Requests	100%	100%
Standard Pre-Service Reconsiderations	100%	100%
Expedited Pre-Service Reconsiderations	Nothing to Report	Nothing to Report
Requests for Payment Reconsiderations	Nothing to Report	Nothing to Report
Pre-Service Independent Review Entity (IRE) Cases Requiring Effectuation	Nothing to Report	Nothing to Report
IRE Payment Cases Requiring Effectuation	Nothing to Report	Nothing to Report
All Administrative Law Judge (ALJ) and Medicare Administrative Contractor (MAC) Cases Requiring Effectuation	Nothing to Report	Nothing to Report
Part C Oral & Written Standard Grievances	100%	100%
Part C Oral & Written Expedited Grievances	100%	100%
Dismissals	100%	N/A

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- OneCare Organization Determinations, Appeals, and Grievances (ODAG):

Audit Area	Timeliness	Member / Provider Notifications
Direct Member Reimbursement Requests	100%	33%
Standard Pre-Service Reconsiderations	100%	33%
Expedited Pre-Service Reconsiderations	Nothing to Report	Nothing to Report
Requests for Payment Reconsiderations	Nothing to Report	Nothing to Report
Pre-Service IRE Cases Requiring Effectuation	Nothing to Report	Nothing to Report
IRE Payment Cases Requiring Effectuation	Nothing to Report	Nothing to Report
All ALJ and MAC Cases Requiring Effectuation	Nothing to Report	Nothing to Report
Part C Oral & Written Standard Grievances	100%	46.67%
Part C Oral & Written Expedited Grievances	100%	Nothing to Report
Dismissals	100%	100%

- The lower compliance score for member / provider notifications is due to the following reasons:
  - Resolution letters did not address all member grievances
  - Direct member reimbursement requests did not include the date the plan received the appeal on the acknowledgement letter issued to the member
  - Standard pre-service reconsiderations did not include the Non-Discrimination Notice in the member's threshold language

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of OneCare grievances and 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 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 grievances and appeals within regulatory requirements.

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- OneCare Connect Service Authorizations Requests, Appeals and Grievances (SARAG):

Audit Element	Timeliness	Member / Provider Notifications
Standard Plan Level Appeals	100%	90%
Expedited Plan Level Appeals	100%	100%
State Fair Hearing Decisions Requiring Effectuation	Nothing to Report	Nothing to Report
IRE Cases Requiring Effectuation	Nothing to Report	Nothing to Report
IRE Payment Cases Requiring Effectuation	0%	100%
ALJ and MAC Cases Requiring Effectuation	Nothing to Report	Nothing to Report
Standard Grievances	100%	70%
Expedited Grievances	100%	95%

- The lower compliance score for timeliness was due to a lack of evidence for written provider notifications being sent timely.

- The lower compliance score for member / provider notifications was due to the following reasons:
  - No medical records received
  - Resolution letter issued was not in 6th grade reading level
  - Resolution letters did not address all the member's grievances
  - Notification letters were issued untimely

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of OneCare Connect grievances and 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 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 grievances and appeals within regulatory requirements.

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- OneCare and OneCare Connect Coverage Determinations, Appeals and Grievances (CDAG):

  - There were no findings identified during the review of OneCare and OneCare Connect Part D coverage determinations, appeals and grievances during this audit.

6. Health Network Monitoring: Medi-Cal [a\]

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
November 2019	83%	80%	94%	89%	91%	72%	93%	84%	77%	93%	100%	61%	87%
December 2019	76%	84%	89%	72%	61%	86%	89%	68%	74%	83%	50%	53%	74%
January 2020	78%	84%	87%	90%	84%	86%	91%	82%	76%	87%	53%	74%	62%

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

  - Based on a focused review of select files, three (3) health networks drove the lower compliance letter score. Eight (8) out of nineteen (19) files received from the three (3) health networks were deficient. Deficiencies for the lower letter scores include the following:
    - Failure to describe why the request did not meet criteria in lay language
    - Failure to provide language assistance program (LAP) insert in approved threshold languages
    - Failure to provide member with information on how to file a grievance
    - Failure to provide letter in member's primary language
    - Failure to provide letter with description of services in lay language
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer
    - Failure to provide referral back to primary care provider (PCP) on denial letter
    - Failure to include name and contact information for health care professional responsible for the decision to deny or modify

  - Based on the universe of Medi-Cal authorizations for December 2019, CalOptima's health networks received an overall compliance score of 99% for timely processing of routine authorization requests and a compliance score of 98% for timely processing of expedited authorization requests.

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused

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review of prior authorization requests. 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 authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	98%	95%	99%	92%
December 2019	98%	97%	99%	95%
January 2020	98%	99%	99%	95%

  - Scores for the month of January 2020 file reviews for Medi-Cal claims improved for paid claims accuracy compared to December 2019 file review scores. All other scores remained the same.

  - Based on the universe of Medi-Cal claims for December 2019, CalOptima's health networks received an overall compliance score of 94% for timely processing of claims.

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
November 2019	100%	NTR	100%	100%	91%	100%	75%	95%
December 2019	75%	100%	91%	87%	91%	100%	82%	88%
January 2020	100%	100%	97%	100%	94%	100%	96%	96%

  - Overall scores for OneCare utilization management increased from December 2019 to January 2020.

  - Based on the universe of OneCare authorization requests for CalOptima's health networks for December 2019, CalOptima's health networks received an overall compliance score of 74% for timely processing of standard Part C authorization requests and 77% for timely processing of expedited Part C authorization requests.

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by 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 authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	100%	100%	89%	100%
December 2019	100%	100%	100%	98%
January 2020	99%	100%	99%	99%

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- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 100% in December 2019 to 99% in January 2020 due to untimely processing of multiple claims. The lower score was driven by one (1) health network with one (1) file marked deficient for paid claim timeliness out of the total ten (10) files received for January 2020 from that health network.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in December 2019 to 99% in January 2020 due to untimely processing of multiple claims. The lower score was driven by one (1) health network with one (1) file marked deficient for denied claim timeliness out of the total ten (10) files received for January 2020 from that health network.

- Based on the universe of OneCare claims for CalOptima's health networks for December 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 75% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 89% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the 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.

8. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
November 2019	91%	100%	93%	81%	82%	96%	73%	96%	57%	84%	95%
December 2019	95%	100%	89%	91%	84%	68%	87%	85%	100%	100%	100%
January 2020	95%	100%	92%	96%	94%	65%	86%	91%	100%	84%	79%

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for timeliness. Five (5) of the eighteen (18) files received from the four (4) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:

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- Failure to meet timeframe for decision (Routine – 5 business days)
- Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM). All three (3) files received from the health network were deficient. The lower scores for CDM were attributed to failure to cite criteria for decision.

➢ Based on a focused review of select files, one (1) health network drove the lower compliance letter score. All three (3) files received from the health network were deficient. Deficiencies for the lower letter scores include 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 provide referral back to primary care provider (PCP) on denial letter
- Failure to include name and contact information for health care professional responsible for the decision to deny or modify

➢ Based on the universe of OneCare Connect authorization requests for CalOptima's health networks for December 2019, CalOptima's health networks received an overall compliance score of 88% for timely processing of routine authorization requests and 87% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. 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 authorizations within regulatory requirements.

- <u>OneCare Connect Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2019	97%	98%	98%	97%
December 2019	95%	99%	99%	98%
January 2020	90%	99%	99%	95%

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- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 95% in December 2019 to 90% in January 2020 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks due to four (4) files marked deficient for paid claims timeliness out of the twenty-one (21) files received for January 2020.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 98% in December 2019 to 95% in January 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by three (3) health networks with ten (10) files marked deficient for denied claims accuracy out of the sixty (60) files received for January 2020.

- Based on the universe of OneCare Connect claims for CalOptima's health networks for December 2019, CalOptima's health networks received the following overall compliance scores:
  - 87% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 87% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 88% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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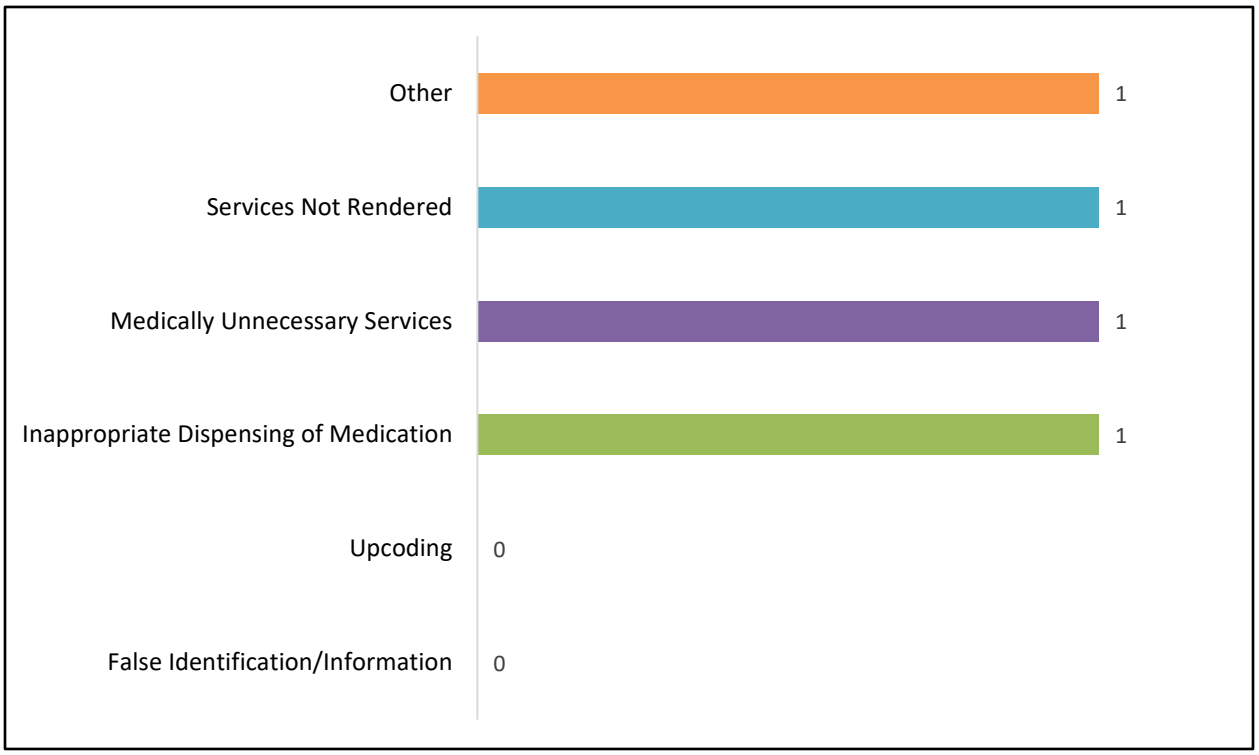
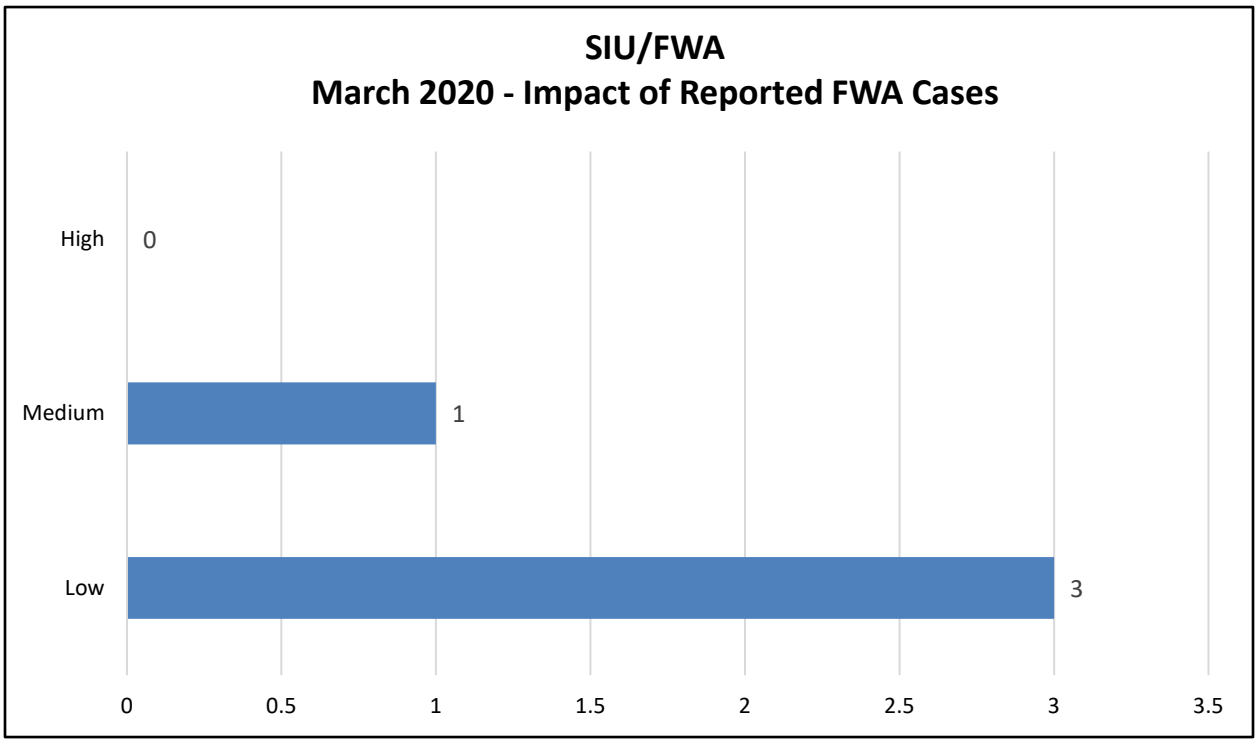
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in March 2020)





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.

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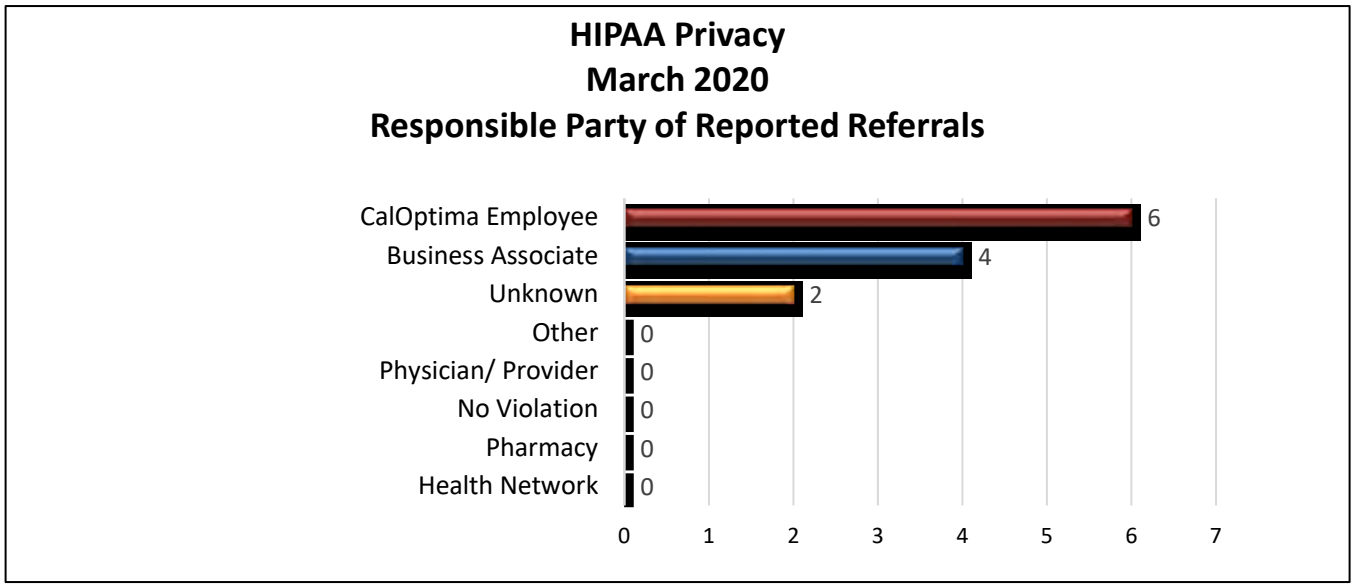
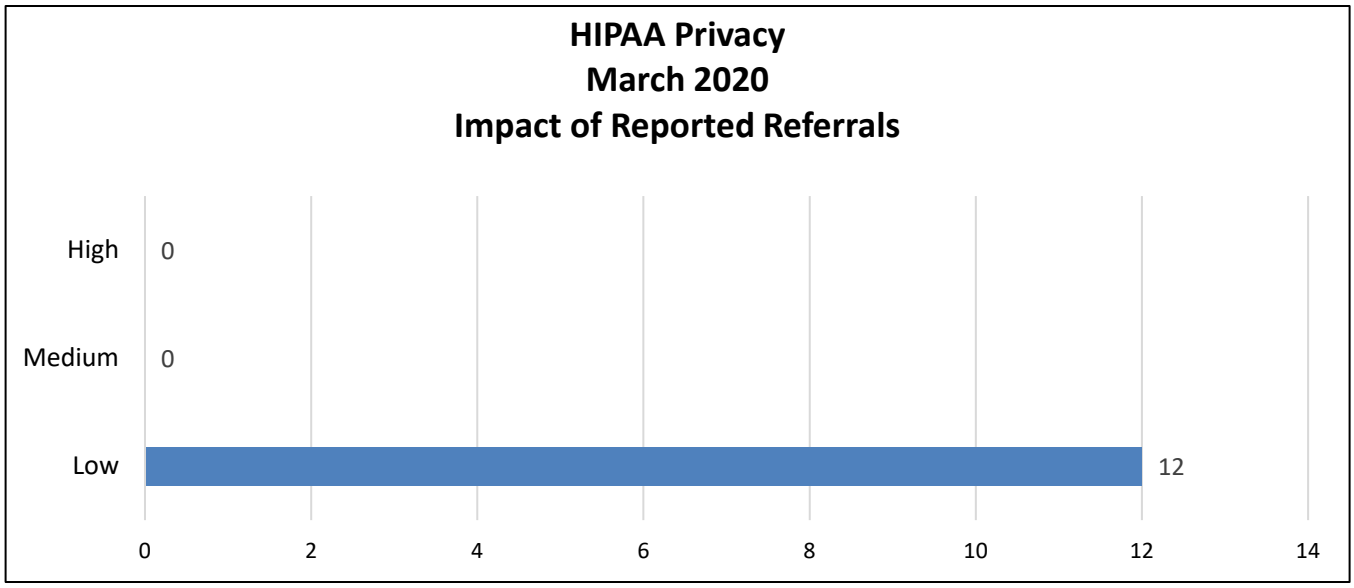
E. Privacy Update: (March 2020)





Total Number of Referrals Reported to DHCS (State)	12
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**12**

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.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

April 13, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: April Board of Directors Report

As much of Washington shut down in March due to the novel coronavirus (COVID-19) outbreak, Members of Congress and their staff worked to draft and pass several major pieces of legislation in response to the crisis. With U.S. cases likely nearing their peak in April, further legislation will aim to bolster the health care system and mitigate the deleterious impact of the outbreak on the economy. This report covers legislative developments through April 13, 2020.

Congressional Response

In response to the COVID-19 outbreak, Congress has passed three major pieces of legislation to provide relief to the health care system, businesses, and individuals; further legislative activity is expected as the crisis continues to strain health systems and the economy.

Phase 2

Following the enactment of the $8.3 billion Coronavirus Preparedness and Response Supplemental Appropriations Act (Phase 1) on March 6, Congress quickly took up and passed the Families First Coronavirus Response Act (Phase 2). The Families First Act, signed into law on March 18, required employers to provide employees affected by COVID-19 with two weeks of emergency paid sick leave. The package also expanded family and medical leave and provided for enhanced unemployment insurance.

The health care provisions of the Families First act required public and private payers, including Medicaid, to cover COVID-19 diagnostic testing at no cost to patients. The package also appropriated $1 billion to reimburse providers for the costs of testing services provided to uninsured individuals. The law permits states to extend Medicaid eligibility to uninsured populations for the purposes of such testing and increases the Medicaid Federal Medical Assistance Percentage (FMAP) by 6.2 percentage points during the public health emergency. In order to receive the increase, states and territories must not restrict their eligibility standards beyond what they were at the date of enactment.

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Phase 3

Soon after passage of the Phase 2 package, work began on a broader stimulus bill to provide relief to individuals, small businesses, and health care providers. Following a week of intense bipartisan negotiations, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The $2.2 trillion measure – considered the largest relief package in U.S. history – included direct payments to individuals; loans, tax credits, and other aid for small businesses; enhanced unemployment insurance; economic relief for local and state governments; and federal assistance for hard-hit industries such as airlines.

The health care provisions of the CARES Act span the jurisdiction of several Senate committees and are principally designed to offer financial support and flexibilities to providers as they care for patients during the public health emergency. The CARES Act suspends sequestration-mandated cuts on Medicare claims from May 1, 2020 through December 31, 2020. In addition, the Act creates a new 20 percent add-on payment under the Medicare inpatient prospective payment system (IPPS) for care provided to patients with COVID-19, and expands a program to provide hospitals with advance Medicare payments during the public health emergency, among other new resources and flexibilities for providers.

The CARES Act also includes an expansion of telehealth under Medicare, eliminating a provision from the Phase 1 package that required providers to have a pre-existing relationship with a patient in order to provide telehealth services during the emergency period. Federally qualified health centers and rural health clinics will be allowed to provide telehealth services, and high-deductible health plans are permitted to cover telehealth before an enrollee reaches their deductible.

Additional flexibilities are also provided to post-acute care providers, waiving certain regulatory requirements for inpatient rehabilitation facilities, long-term care hospitals and home health agencies. The package also prioritizes patient access to diagnostics and care related to the outbreak. With respect to testing, the CARES Act clarifies that diagnostics covered under the Phase 2 bill include all cleared and approved tests for COVID-19, including those authorized by the Food and Drug Administration (FDA) under an emergency use authorization and those authorized by a state.

The Act includes several provisions to address potential shortages of medical supplies, prescription drugs, and medical devices, including new mandatory reporting for manufacturers, as well as measures to alleviate health professional workforce shortages during the public health emergency.

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The CARES Act extends a number of health care programs and provisions that were set to expire on May 22, 2020, providing funding through November 30, 2020 for community health centers, the National Health Service Corps, the Teaching Health Center Graduate Medical Education program, the Special Diabetes Program, and the Special Diabetes Program for Indians. The Act extends several expiring Medicaid programs through November 30, including the Money Follows the Person demonstration and Medicaid spousal impoverishment protections, and expands the Community Mental Health Services demonstration to two additional states, as selected by the Centers for Medicare & Medicaid Services (CMS). The Act delays scheduled Medicaid disproportionate share hospital (DSH) payment reductions until December 1, 2020.

Division B of the CARES Act includes supplemental appropriations for a number of health-related programs and activities under the Department of Health and Human Services (HHS). This includes $100 billion for a new program to reimburse, through grants or other mechanisms, providers for coronavirus-related expenses or lost revenues. HHS began distributing payments to provider and suppliers this month using a formula based on 2019 Medicare fee-for-service payments. A subsequent round of grants is expected to reimburse providers who predominantly treat patients covered by Medicaid, rather than Medicare.

The Act also includes $3.5 billion for the development and purchasing of vaccines and therapeutics for COVID-19 and $16 billion for the Strategic National Stockpile to procure personal protective equipment and other supplies. $250 million is provided for grantees of the Hospital Preparedness Program. The measure also adds $4.3 billion in funding for the Centers for Disease Control and Prevention (CDC), including $1.5 billion in designated funding for state and local public health activities and $300 million for the Infectious Diseases Rapid Response Reserve Fund. Additional funding includes $945 million for the National Institutes of Health (NIH) for research activities related to COVID-19, and an additional $200 million to the CMS for program management, including funds to assist nursing homes with infection control.

Further Legislation

On April 9, the Senate failed a procedural vote to get consent to consider either a Republican or Democratic proposals for interim COVID-19 relief funding, informally dubbed “Phase 3.5.” The Republican proposal is limited to $250 billion in additional Small Business Administration funding for Paycheck Protection Program (PPP) loans and technical corrections. In addition to this increase for the PPP, the Democrats’ counterproposal included an additional $100 billion for health care providers via the Public Health and Social Services Emergency fund and an additional $150 billion to states and localities. Senate Minority Leader Chuck Schumer (D-NY) and House Speaker Nancy Pelosi (D-CA) are also calling for additional funding for testing capacity, personal protective equipment (PPE), and the Supplemental Nutrition Assistance

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Program (SNAP). Negotiations are expected to continue, and there will be significant pressure to include health care funding in addition to small business loans.

Meanwhile, many health care providers and other businesses are already looking ahead to a "Phase 4" package that could include a broad array of federal aid and relief measures. Speaker Pelosi and Senate Minority Leader Schumer initially proposed that the package would include Democratic agenda items such as infrastructure funding and rural broadband access, but Republicans balked at the idea. More recently, Speaker Pelosi has called for a targeted Phase 4 bill that builds on the CARES Act, extending enhanced unemployment insurance and adding funds for small business relief. On the health care side, the Phase 4 package could include additional funding for health care providers; further telehealth expansion; enhanced liability protections for manufacturers and distributors; delay of the Medicaid Fiscal Accountability Regulation (MFAR); competitive bidding reform; and financial relief for associations.

The House and Senate are not expected to reconvene before April 20, although staff are continuing to work on the next stimulus package. A reluctance to bring Members back to Washington for votes could encourage Leadership to devise a Phase 4 package that can pass by unanimous consent.

Medicaid Waivers

President Trump's declaration of a national emergency on March 13 enabled CMS to waive certain requirements in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) under Section 1135 of the Social Security Act. Medicaid waivers available under section 1135 include temporary suspension of prior authorization requirements; modification of timeline requirements for state hearings and appeals; relaxation of provider enrollment requirements; and flexibility around public notice and submission deadlines for certain COVID-19 related Medicaid state plan amendments.

CMS began accepting and approving 1135 Medicaid waiver requests on March 22. California received its initial set of approvals for flexibilities under Section 1135 on March 23, which has been augmented pursuant to additional correspondence between the State and CMS. Though the federal pronouncements of California's temporary flexibilities are described primarily in terms of fee-for-service, the State has applied most of these policies to managed care as well. As of April 13, 48 states and the District of Columbia have received approval for their 1135 waiver requests. Section 1135 waivers are effective retroactive to March 1, 2020, and will end upon termination of the public health emergency.

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Affordable Care Act Case

On April 2, the Supreme Court granted parties' request for an extended briefing schedule in *Texas v. United States*. The new schedule will still allow oral arguments to be heard in the next term beginning in October, though it remains to be seen whether the COVID-19 outbreak will affect those plans. After postponing oral arguments throughout March and April, the Court recently announced that it will start hearing oral arguments by teleconference beginning in May.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

April 3, 2020

COVID-19 UPDATE: 2020 LEGISLATIVE PROCESS
Edelstein Gilbert Robson & Smith LLC

As the COVID-19 crisis deepens, it appears that California's proactive approach may be working. Experts have expressed cautious optimism that California's shelter in place order is "bending the curve" as the Governor had hoped. In discussing this earlier in the week, Governor Newsom warned that continuing to adhere to the state's orders would be essential and that more work was needed to ensure an adequate number of hospital beds are available in the coming weeks.

The Governor and his team continue to refine existing Executive Orders and issue new ones. Earlier this week, the Governor signed an EO providing an extension to various tax filing deadlines for small business owners. On Thursday, he followed up with an announcement that small businesses collecting sales tax would be given a twelve-month reprieve from remitting up to $50,000 to the state. This effectively amounts to a bridge loan that would allow businesses financial support while they apply for Federal loans and grants.

Schedule and Return of the Legislature
The Legislature's unprecedented choice to recess its regular session until at least April 13 in response to COVID-19 has put the Legislature's schedule for the remainder of the year into question. We wanted to share what we have learned in the last few weeks about how the Legislature may proceed and our thoughts on what it could mean for legislation we are engaged in on your behalf.

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regardless of how much legislators voluntarily “give up” bills, the state’s financial situation will make it harder to pass bills with any significant costs to the state.

All of that said, Assembly and Senate Leadership have made no formal decisions on when they will return or how to manage their workload. Any decision they do make will likely be heavily influenced by when the Legislature is able to return. In the likely event that the Legislature chooses to curtail its workload, you can expect some efforts to work around those restrictions. In fact, if leadership and the Governor are willing there are several options that would allow legislators to get their bills passed in 2020 or early 2021. While it’s hard to predict exactly what that would look like, several examples are provided below.

Special Session
The Governor can “on extraordinary occasion” call the Legislature into Special Session. In theory, this authority exists to address emergencies and specific issues. However, if the proclamation calling for the Special Session was broad enough, this would allow legislators to reintroduce and attempt to pass many of the bills they have introduced in the regular session thus far. Legislative leaders have a lot of power to bend the rules of a special session in favor of or against specific bills. It can be called concurrently with the regular session and, most importantly, would allow the Legislature to continue working on bills beyond August 31. Bills passed in a special session become law 91 days after they are signed by the Governor.

Expedited Process for End of 2020 and Beginning of 2021
After the November General Election, the newly elected 2021-2022 Legislature will convene in Sacramento in early December. This is usually a quiet time of year. Any bill that cannot move forward in 2020 can be reintroduced when the Legislature reconvenes in December. There is a rumor that legislators who cannot move their bills in the regular session will be afforded an expedited process for those bills in December 2020 and January 2021.

Conference Committee
Every year once the Assembly and Senate have adopted their respective versions of a state budget a Budget Conference Committee, composed of the Budget Committee Chairs and several members of each house, meet to negotiate and agree on a version of the budget both houses will pass. In practice, the process of negotiating a compromise is very opaque and is heavily influenced by leadership in each house and negotiations with the Governor. The Budget Conference Committee, or a conference committee appointed specifically to hear “essential bills,” is another option for the Legislature to quickly review and adopt bills. While a conference committee process would only be possible for a limited number of “essential” bills, it would afford the least opportunity for public input on legislation.

What Does all this Mean?
As we noted above, no definitive decision has been made yet. Exactly what course of action the Legislature pursues will depend a lot on the course of the COVID-19 crisis

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and when the Legislature can safely reconvene. What is most important is understanding that if the Legislature does choose to bend its own rules to hear and act on new bills it will likely do so on an expedited timeline and at the expense of public process. Consequently, it is more important than ever that stakeholders with important business before the Legislature carefully monitor the Capitol and be ready to engage.

Accordingly, we are staying close to things on your behalf and will keep you apprised of further developments.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

April 10, 2020

COVID-19 UPDATE: BUDGET
Edelstein Gilbert Robson & Smith LLC

This week, Governor Newsom announced a plan to procure 200 million protective masks and other protective equipment per month. The Governor has already ordered $1.4 billion worth of equipment. The infusion of equipment will be enough to meet the state's needs and even ease the scarcity impacting other states as well. This announcement followed closely on the heels of Newsom's decision to lend 500 of the state's ventilators to the national stockpile for use by states that are heavily impacted by the pandemic such as New York.

In making his announcements, Governor Newsom has painted a picture of California as a "nation state" with the abundant resources needed to help our "fellow Americans" in this crisis. The Governor's efforts have the potential to improve public health outcomes not just in California but elsewhere in the country. They have also garnered national attention and given the Governor an opportunity to make connections with Governors and leaders outside of the state.

Meanwhile, the Senate President Pro Tem and Assembly Speaker announced yesterday that they would begin conducting oversight hearings of the Governor's activities. While the leaders were careful to express confidence in the Governor's approach, they noted that they promised to provide oversight prior to recessing on March 16. In making the announcement, the Pro Tem and Speaker stated that the hearings would occur in advance of the Legislature returning to session and that no

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Mr. Ting went on to explain that once the extended July 15 filing deadline for personal income taxes passes, the Governor and Legislature will have a reliable understanding of the state's revenue shortfall and will then revisit the budget in an "August Revision." As of now, rough estimates predict that the state could lose anywhere from $8 to $20 billion of revenue due to economic turmoil caused by COVID-19. Reflecting this, Mr. Ting warned that the state would likely need to consider sizeable ongoing reductions to major programs in August.

While the state is facing a financial challenge, it does so with roughly $19.2 billion in reserves. Much of this money could be appropriated when the Legislature adopts its June budget. As we noted two weeks ago, another bright spot in the 2020-2021 budget is the passage of the Federal CARES Act. The CARES Act is expected to provide $25 billion to California which includes payments to the state, local governments, and direct payments to individuals and businesses. The state will receive $8.4 billion of this from the Corona Virus Relief Fund for healthcare response actions.

We will continue to keep you apprised of further developments.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

April 17, 2020

COVID-19 UPDATE: Employment and Re-Opening the Economy
Edelstein Gilbert Robson & Smith[LLC]

On Thursday, President Trump publicly turned the re-opening of business, schools and gatherings over to the Governors of the states. This ends any speculation or debate over whether the President has the authority to force states to eliminate stay-at-home orders against their will or advice of public health officials.

As for re-opening the California economy, earlier in the week, Governor Newsom outlined the six factors he will use in deciding when and how to modify the statewide state-at-home order and he placed no timeline on when modifications of his order would occur. Those six factors are: Expanded testing to enable track and trace illness, Protecting populations vulnerable to COVID-19 infection; addressing the needs of hospital delivery system, developing protocols and therapeutics for recovery; redrawing floor plans to conduct business and schools with appropriate physical distancing; develop tools to know when to reinstate more vigorous controls (like shelter in place).

Protecting populations vulnerable to COVID-19 is one of the six factors listed above and the Governor has already enacted substantive Executive Orders in the employment context to protect Essential Critical Infrastructure workers who are vulnerable to COVID-19 infection. We expect additional Executive Orders to be forthcoming for these workers in the coming weeks and it is reasonable to assume that similar orders will be considered applicable to the general workforce and all employers as a condition for relaxing stay-at-home orders and returning people to school, work, and public spaces.

Paid Sick Leave
On April 16, the Governor issued an Executive Order to ensure that employees from large employers in the food sector industry, which includes the whole food distribution chain from agriculture, packing and canning, delivery, and grocery stores are eligible for a two-week expanded State Supplemental Paid Sick Leave program. This specific state paid leave closes a gap left by the federal paid leave which exempted employers with more than 500 employees.

At the same time, several local jurisdictions have adopted or are considering adopting similar paid leave programs for all COVID-19 impacted employees.

Worker Safety Guidelines and Protections
Since the beginning of the COVID-19 crisis, the California workplace safety agency, Cal-OSHA has actively issued guidance to all employers, with specific requirements on employers with employees subject to higher risk of infection. For example, Cal-OSHA has adopted requirements and procedures for specific industries, including grocery, child care, health care and there are specific new requirements for businesses already subject to airborne infectious disease regulations. At the same time, Cal-OSHA

guidance for general business advises that employers actively discourage sick employees from coming to work, ensuring availability of hand-washing stations, and routine disinfecting of the workplace.

The new requirements agreed to by the grocery industry and its represented labor workforce could become a model for future requirements on many customer-facing industries. https://dir.ca.gov/dosh/Coronavirus/COVID-19-Infection-Prevention-in-Grocery-Stores.pdf

Workers' Compensation

Not yet addressed in any Executive Order is the role of California's no-fault workers' compensation insurance program. Right now, care for those who become ill from COVID-19 infection is paid for by Medi-Cal or private insurance. We expect that workers' compensation claims are being made by employees who are infected at work and that the existing claims process is underway.

The California Labor Federation has expressed in a letter to the Governor that any COVID-19 infection by a health care worker, firefighter, EMS, frontline law enforcement, and all employees deemed Essential Critical Infrastructure be conclusively presumed to have occurred at work. It is unclear whether and how the Governor will act on this request in an Executive Order. Absent an Executive Order, we expect this matter to surface in a bill when the Legislature returns.

However, we believe greater clarity and rules governing how workers' compensation claims are considered and adjudicated will be part of the equation before the stay-at-home orders are lifted for non-essential businesses that are currently closed.

All these items are fast-moving. We will keep you apprised of developments.

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2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Would include billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch
AB 89 Ting	**Emergency Budget Response to COVID-19:** Similar to SB 89, would appropriate $500 million General Fund by amending the Budget Act of 2019. Funds are to be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, would authorize additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 117 Ting	**Emergency Budget Response to COVID-19 at Schools:** Similar to SB 117, appropriate $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Similar to AB 89, appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Similar to AB 117, appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2266 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create the Certified Support Specialist (CSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services to include CSS as a provider type, covered by Medi-Cal, no sooner than January 1, 2022. If federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	**01/15/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. Additionally, if a child 2 to 6 years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide that test. This bill would also require the Department of Health Care Services to notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2277 Salas	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to impose requirements of the contracted provider to conduct blood lead screenings tests and for the provider to identify patients eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screenings tests and identify eligible beneficiaries on a monthly basis.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**02/24/2020** Referred to Committees on Health; Environmental Safety and Toxic Materials **02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**03/05/2020** Referred to Committees on Health; Judiciary **02/14/2020** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2042 Wood	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2055 Wood	**CalAIM Drug Medi-Cal and Behavioral Health:** Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2170 Blanco Rubio	**CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:** Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	**02/20/2020** Referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
SB 910 Pan	**CalAIM Population Health Management:** Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	**02/03/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 916 Pan	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**02/03/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**01/17/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**01/30/2020** Referred to Committee on Health **01/21/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**02/20/2020** Referred to Committee on Health **02/13/2020** Introduced	CalOptima: Watch
AB 3118 Bonta	**Medically Supportive Food and Nutrition Services:** Would include medically supportive food and nutrition services as a Medi-Cal Benefit. Would also include transportation services for a beneficiary to access healthy food as a way to help prevent or manage chronic illnesses.	**03/09/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2535 Mathis	**Denti-Cal Education Pilot Program:** Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to SB 1073, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	**05/16/2019** Committee on Appropriations; Hearing postponed at the request of the Committee **04/02/2019** Passed Committee on Health **02/15/2019** Introduced	CalOptima: Watch
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
SB 1073 Gonzalez	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to AB 526, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**02/18/2020** Introduced	CalOptima: Watch

HOMELESSNESS

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

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1907 Santiago, Gipson, Quirk-Silva	**California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:** Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.	**01/30/2020** Referred to Committees on Natural Resources; Housing and Community Development **01/08/2020** Introduced	CalOptima: Watch
AB 2295 Quirk-Silva	Fairview Developmental Center: Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**02/14/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2625 Boerner Horvath	**Ground Emergency Medical Transportation (GEMT):** Would require managed care plans that offers coverage for GEMT services to include those services as in-network services.	**03/02/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**02/20/2020** Referred to Committee on Health **02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	**02/20/2020** Referred to Committee on Health **02/05/2020** Introduced	CalOptima: Watch
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Would establish the Office of Drug Contracting and Manufacturing (Office) to reduce the cost of prescription drugs. No later than January 1, 2022, would require the Office to contract or partner with no less than one drug company or generic drug manufacturer, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs.	**01/13/2020** Introduced	CalOptima: Watch
SB 1084 Umberg	**Secure Dispensing of a Controlled Substance:** Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial no sooner than June 30, 2021. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial within 30 days of receiving a claim. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	**03/05/2020** Referred to Committees on Business, Professions and Economic Development; Judiciary **02/19/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**03/12/2020** Referred to Committees on Aging; Long-Term Care **02/19/2019** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would create the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs to certify nurse practitioners wanting to practice without direct, ongoing supervision of one or more physicians.	**01/27/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Carry-over bill; Moved to inactive filed at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 2871 Fong	**Drug Medi-Cal Reimbursement Rates:** Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	**03/05/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose
AB 2007 Salas	**Telehealth Services for New Patients:** Would no longer require the first visit at a federally qualified health clinic to be an in-person visit. Instead, would allow the new patient the option to utilize telehealth services and become an established patient as their first visit.	**02/14/2020** Referred to Committee on Health **01/28/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2164 Rivas	Telehealth Pilot Program: Would establish a five-year grant and pilot program, to establish the eConsult Services and Telehealth Assistance Program. The grant funding would be available to health centers and community clinics providing care in rural and underserved areas. The pilot program is projected to cost $7.5 million over five-years and would be use for: ■ Conducting infrastructure assessments, clinical objectives, and staffing plans; ■ Procuring technology and software and implementing eConsult services; and ■ Workforce training.	**02/14/2020** Referred to Committee on Health **01/28/2020** Introduced	CalOptima: Watch

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 2002918 Trailer Bill – Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
RN 2003830 Trailer Bill: Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
RN 2006526 Trailer Bill – Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch

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

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

Last Updated: April 20, 2020

2020 Federal Legislative Dates

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

2020 State Legislative Dates

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

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

About CalOptima

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

Board of Directors Meeting
May 7, 2020

CalOptima Community Outreach Summary — April 2020

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's staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update
In response to the COVID-19 pandemic, CalOptima has transitioned how we engage with our community partners. **CalOptima will not be attending in-person Community Collaborative meetings or community events.** In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19.

Community Relations continues to engage and support our community partners amid the COVID-19 pandemic. CalOptima will sponsor the Orange County Women's Health Project's 8th Orange County Women's Health Summit, which will be a **virtual conference live-streamed** on May 29, 2020. The Orange County Women's Health Project is a non-profit collaborative that partners with health care providers, non-profits, government agencies, researchers, educators, business and advocates to identify women's health needs in Orange County, develop recommendations and drive solutions. They are one of few collaboratives that focus primarily on women's health in Orange County.

This year's virtual summit will address "Women's Health Across the Lifespan" with a special focus on the COVID-19 pandemic. The summit will highlight certain health conditions, diseases, and adverse experiences that impact the health of girls and women differently than boys and men. Speakers will share information on how Adverse Childhood Experiences (ACEs) result in associated health conditions and diseases and what local

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efforts are in place to screen for and address these experiences. Additional presentations will examine maternal mental health and various mental health initiatives in the county and statewide. Participants will also have an opportunity to discuss with a panel of speakers about specific needs and health outcomes affecting LGBTQ, individuals, seniors and caregivers living in Orange County.

CalOptima Executive Director, Quality and Population Health Management Betsy Ha, will facilitate the panel discussion on ACEs. She is a strong proponent for CalOptima to act as the lead convener for our community stakeholders to increase awareness and education of the ACEs screening tool. CalOptima will be recognized during the welcome remarks and information about our programs and services. We will be included in the event's electronic program with links to digital literature and resources.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

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 April 7, 2020, **through virtual meetings and teleconference** CalOptima expects to participate in 27 community events, coalitions and committee meeting and does not anticipate in participating in any others during April.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
4/03/2020	• Clinic in the Park Quarterly Collaborative (Virtual Meeting) • Annual Health Care Symposium hosted by Community Clinic Association of Los Angeles and the Coalition of Orange County Community Health Centers (Sponsorship fee of $1,000 included one complimentary registration and agency name and logo displayed online throughout virtual event and sessions)
4/07/2020	• Santa Ana Early Learning Initiative Steering Committee (Virtual Meeting)
4/08/2020	• Orange County Aging Service Collaborative General (Virtual Meeting) • Health Care Task Force Virtual Meeting • Orange County Communication Workgroup (Teleconference Meeting)
4/09/2020	• Buena Park Collaborative (Virtual Meeting) • Kid Healthy Community Advisory Council Meeting (Teleconference Meeting) • Garden Grove Community Collaborative Advisory Meeting (Format Pending)
4/13/2020	• Orange County Veteran's and Military Families Collaborative (Virtual Meeting) • Fullerton Collaborative Meeting (Format Pending)
4/14/2020	• Youth and Wellness Prevention Coalition (Virtual Meeting) • Orange County Cancer Coalition (Virtual Meeting)

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4/15/2020	• Minnie Street Family Resource Center Meeting (Format Pending) • Covered Orange County Steering Committee Meeting (Format Pending) • Orange County Communications Workgroup (Teleconference Meeting)
4/16/2020	• Orange County Disability Coalition Meeting (Format Pending) • Garden Grove Community Collaborative General Meeting (Format Pending) • Orange County Children's Partnership Committee Meeting (Format Pending) • Orange County Women Health Project (Teleconference Meeting)
4/20/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee (Virtual Meeting)
4/21/2020	• Placentia Community Collaborative Meeting (Format Pending)
4/22/2020	• Orange County Strategic Planning for Aging Leadership Council Meeting (Format Pending)
4/23/2020	• Orange County Care Coordination for Kids (Virtual Meeting)
4/27/2020	• Stanton Collaborative Meeting (Format Pending) • Community Health Research and Exchange (Virtual Meeting)
4/28/2020	• Orange County Senior Roundtable (Format Pending)

As of April 7, 2020, CalOptima expects to organize or convene three community stakeholder events, meetings and presentations through virtual meetings and teleconference and does not anticipate in participating in any others during April.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
4/16/20	• Health Network Forum (Virtual Meeting)
4/22/20	• CalOptima Community Based-Organization Presentation for Orange County Council on Aging — Topic: Health Homes Program (Virtual Presentation)
4/29/20	• Cafecito Virtual Meeting — Highlight: Population Health Management (Virtual Meeting)

CalOptima provided one endorsement consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

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1. Provide a Letter of Support to AltaMed Health Services for a grant funding with the Center for Disease Control and Prevention to implement an organization-wide centralized population health program to increase colorectal cancer screening rates.

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.
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 is transitioning how we engage with our community partners and will not be 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 has updated our participation in Community Collaborative meetings and community events. With respect to events for which sponsorship or registration fees have already been paid, we are working to determine if fees can be applied to future events.

+ Exhibitor/Attendee
++ Meeting Attendee

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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.

May

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Saturday, 5/2 9 a.m.–12:30 p.m. (Pending)	+ Clinic in the Park Family Health Day at CSUF Center for Healthy Neighborhoods	Health/Resource Fair Open to the Public	1 Staff	Cal State Fullerton Center for Healthy Neighborhood 320 W. Elm Ave. Fullerton
Monday, 5/4 6–8 p.m. (Pending)	+ Wellness and Prevention Center Mental Health Community Forum	Health/Resource Fair Open to the Public	1 Staff	San Clemente High School 700 Avenida Pico San Clemente
Tuesday, 5/5 9:30–11 a.m. (Pending)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Thursday, 5/7 9–11 a.m. (Pending)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church - St. Andrew's Hall 1855 Orange Olive Rd. Orange
Thursday, 5/7 11 a.m.–1 p.m. (Pending)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main St. Garden Grove
Friday, 5/8 9–10 a.m. (Pending)	++ Orange County Diabetes Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Health Care Agency 1725 W. 17th St. Santa Ana
Monday, 5/11 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr.

+ Exhibitor/Attendee
++ Meeting Attendee

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				Santa Ana
Monday, 5/11 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 5/12 9–11:30 a.m. (Pending)	+ City of Stanton Senior Resource Center	Health/Resource Fair Open to the Public	1 Staff	Stanton Family Resource Center 7800 Katella Ave. Stanton
Tuesday, 5/12 10–11:30 a.m. (Virtual format)	++ Orange County Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 5/12 3:30–5:30 p.m. (Pending)	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 5/13 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 5/14 9 a.m.–12 p.m. (Pending)	++ Refugee Forum Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Thursday, 5/14 10 –11:30 p.m. (Pending)	++ Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 5/14 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Thursday, 5/14 2:30–4:30 p.m. (Conference call)	++ Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 5/14 3:30–5:30 p.m. (Virtual format)	++ State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	2000 East Fourth St. Santa Ana
Monday, 5/18 1–4 p.m. (Virtual format)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Community Center 505 E. Central Ave.

+ Exhibitor/Attendee
++ Meeting Attendee

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				Santa Ana
Tuesday, 5/19 8:30–10 a.m. (Pending)	++ North Orange County Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 5/19 11 a.m.–12 p.m. (Pending)	++ Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library Community Room 411 Chapman Ave. Placentia
Wednesday, 5/20 8:45–10:30 a.m. (Pending)	++ La Habra Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Our Lady of Guadalupe Church 900 W La Habra Blvd. La Habra
Wednesday, 5/20 9:15–11 a.m. (Pending)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 5/20 11 a.m.–1 p.m. (Pending)	++ Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	1300 McFadden Ave. Santa Ana
Thursday, 5/21 8:30–10 a.m. (Pending)	++ Orange County Children's Partnership Committee (OCCP)	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 5/21 11:30 a.m.–1 p.m. (Pending)	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Monday, 5/25 12:30–1:30 p.m. (Pending)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 5/26 7:30–9 a.m. (Pending)	++ OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Thursday, 5/28 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building

				1120 W. La Veta Orange
Friday, 5/29 8:30 a.m.–2:30 p.m. (Virtual format)	+ 8th Orange County Women's Health Summit hosted by Orange County Women's Health Project	Community Presentation Open to the Public	$1,000 Sponsorship 2 Staff	UC Irvine Beckman Center 100 Academy Way Irvine